Safer Baby Bundles in Queensland Using a Modified Breakthrough Series Collaborative Approach

Presented by:

Michael Rice & Colette McIntyre

Patient Safety and Quality

Clinical Excellence Queensland

November 2024

Safer Baby Bundle

WORKING TOGETHER TO REDUCE STILLBIRTH

More Information

saferbabybundle@health.qld.gov.au

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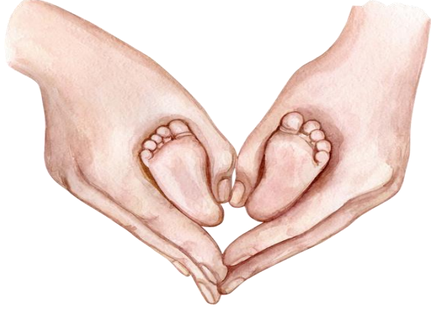
AUDAX AT FIDELIS

Queensland Government



Conflict of interest

- We have no conflict of interest to declare.
- This work was conducted as an improvement project as part of our role in Clinical Excellence Queensland
- Funding was provided from the division’s operational budget.
- Attendance at this conference is supported by Clinical Excellence Queensland.

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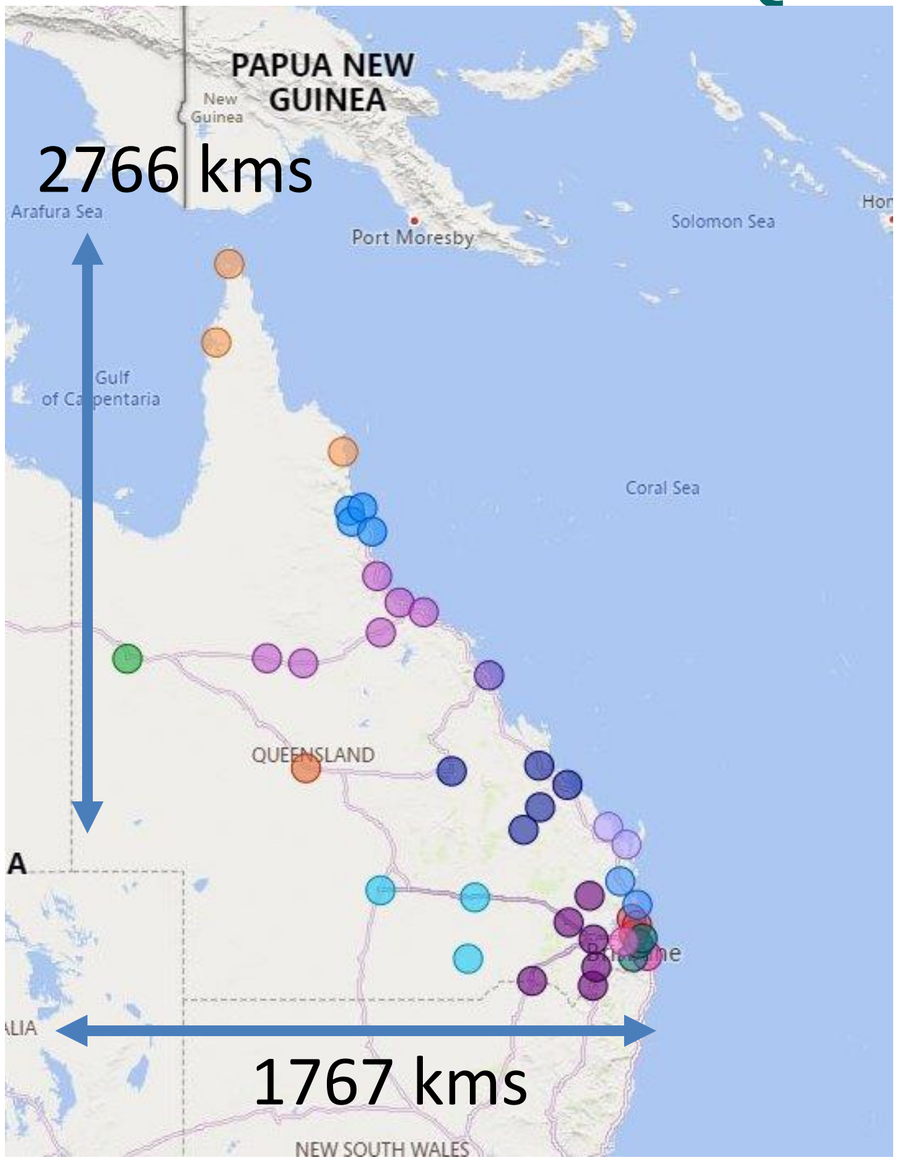
Queensland, Australia



Qld population - 5,562,452
45 antenatal clinics
1,727,000 sq kms

7 x size of Great Britain (population of 69,138,192) with >12 times less population

challenging to get to everyone!

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Background

Background

In Australia 6 babies are born still every day (AIHW, 2024[1])

The Queensland Safer Baby Bundle Improvement Project was part of a national initiative to reduce preventable stillbirth post 28 weeks, in Australia, by 20%, by 2023 (now 2025)

Use of an evidence-based antenatal bundle of care

Targeting all sites across Queensland with an antenatal clinic using any model of maternity care

Partnering with midwives and obstetricians

From October 2019 to December 2022

Hosted by Clinical Excellence Queensland (1.2fte)

Using a modified Breakthrough Collaborative Series

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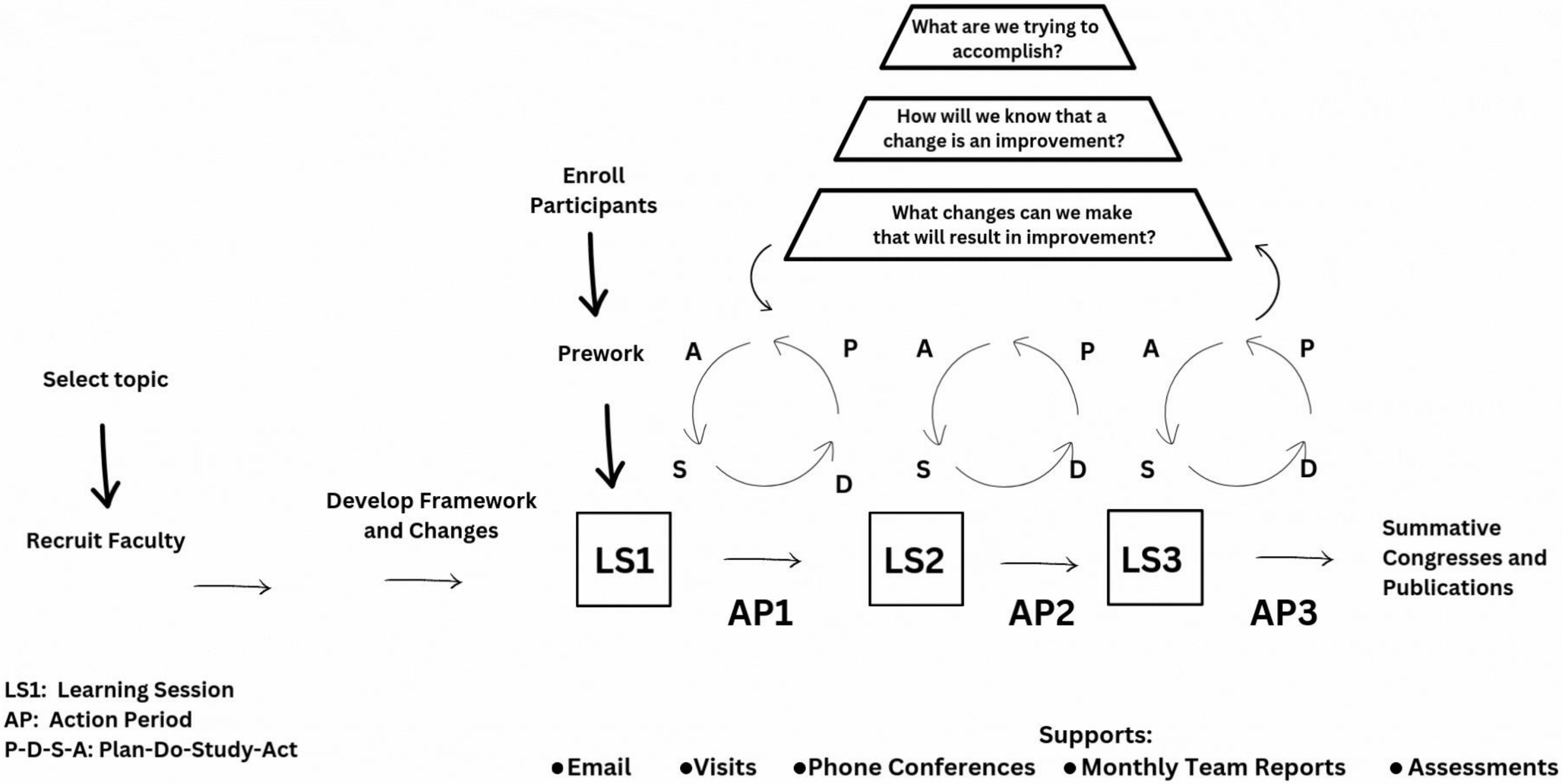
IHI Breakthrough Series Collaborative and Model for Improvement



Institute for Healthcare Improvement. (2003). *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement (IHI Innovation Series white paper)*

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Method

What did we do differently?

No SPC charts. Use of dashboard from a variety of data sources

No requirement to undertake formal PDSAs

Completion of Stillbirth CRE eLearning module prior to commencement

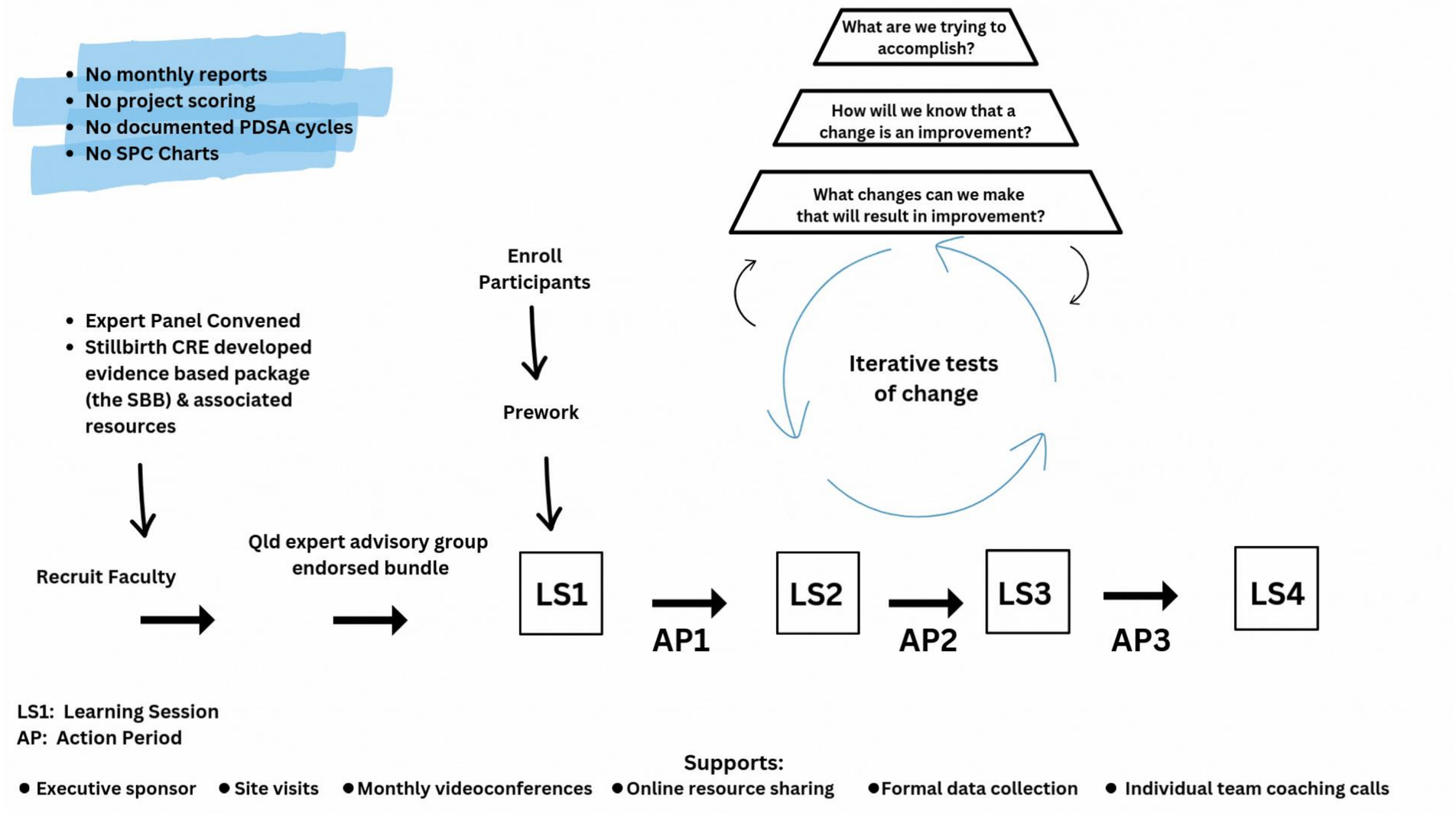
No fee to join

Added a final showcase and sustainability focussed learning session

No formal written reporting of progress or project progress scores

Support - site visits / 1:1 coaching

Modified Breakthrough Series Collaborative



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Method

Steering committee to oversee

Engagement with:

- senior obstetric and midwifery clinicians via local teams
- executive sponsors via written agreements
- consumers – steering committee and local sites
- First Nations
- Stillbirth CRE – resources, advice, steering committee, national guidance

Method

Suite of measures for dashboard

Outcome (1)

Process (12 + 5 optional)

Balancing (4)

Aligned with national measures

Data sources

Clinician survey

Chart audit using Redcap

Quitline data

Perinatal data collection

Consumer survey

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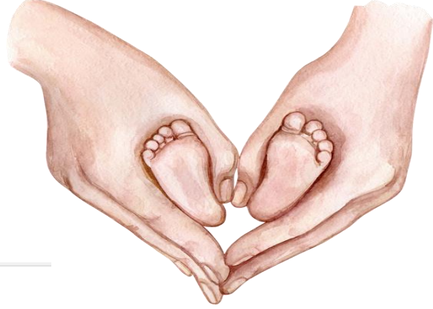
Dashboard



Number of women attended for antenatal care

16,123

Number of women with documented risk assessment for FGR at first antenatal booking visit

9,651

Proportion of women with documented risk assessment for FGR at first visit

59.9% 100% Target

Number of women (at any gestation) whose care was escalated as per FGR care pathway

8,343

Proportion of women (at any gestation) whose care was escalated appropriately as per the FGR care pathway

51.7% 80% Target

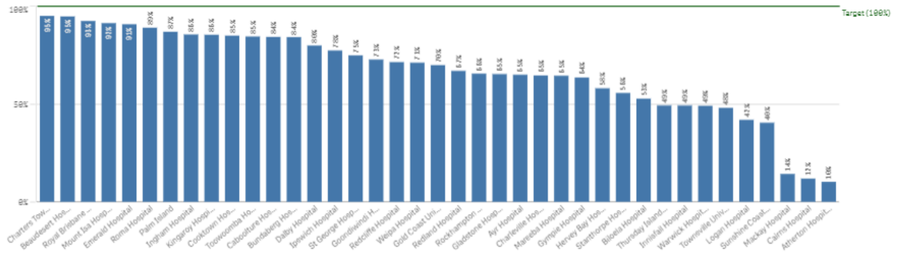
Number of women with SFH measurement taken and plotted on growth chart from 24 weeks gestation

5,046

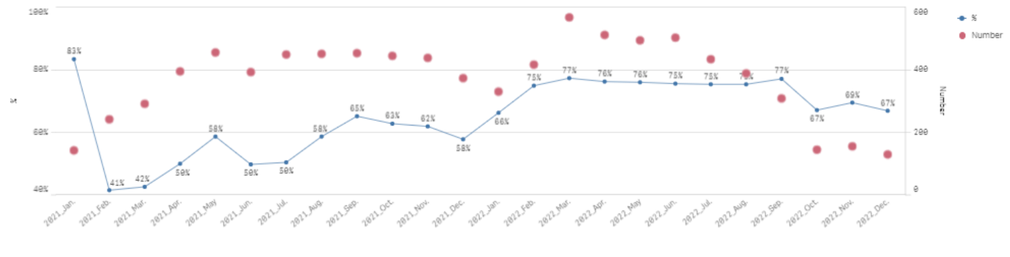
Proportion of of women with SFH measurement taken and plotted on growth chart from 24 weeks gestation

31.3% 80% Target

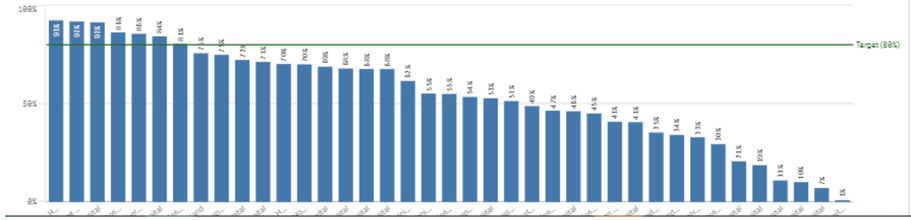
By site - Proportion of women with documented risk assessment for FGR at first antenatal visit



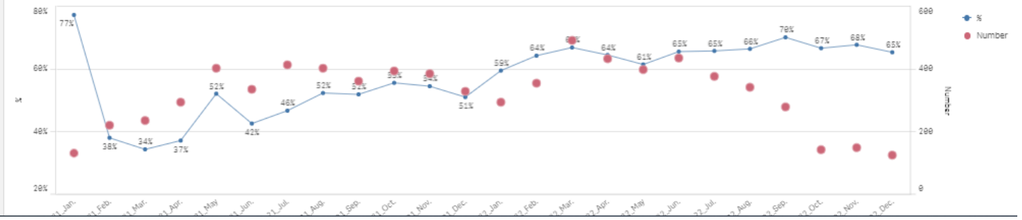
Run chart - Proportion & number of women with documented risk assessment for FGR at first antenatal visit



By site - Proportion of women (at any gestation) identified as at risk of FGR whose care was escalated as per the FGR care pathway



Run chart - Proportion & number of women (at any gestation) identified as at risk of FGR whose care was escalated as per the FGR care pathway



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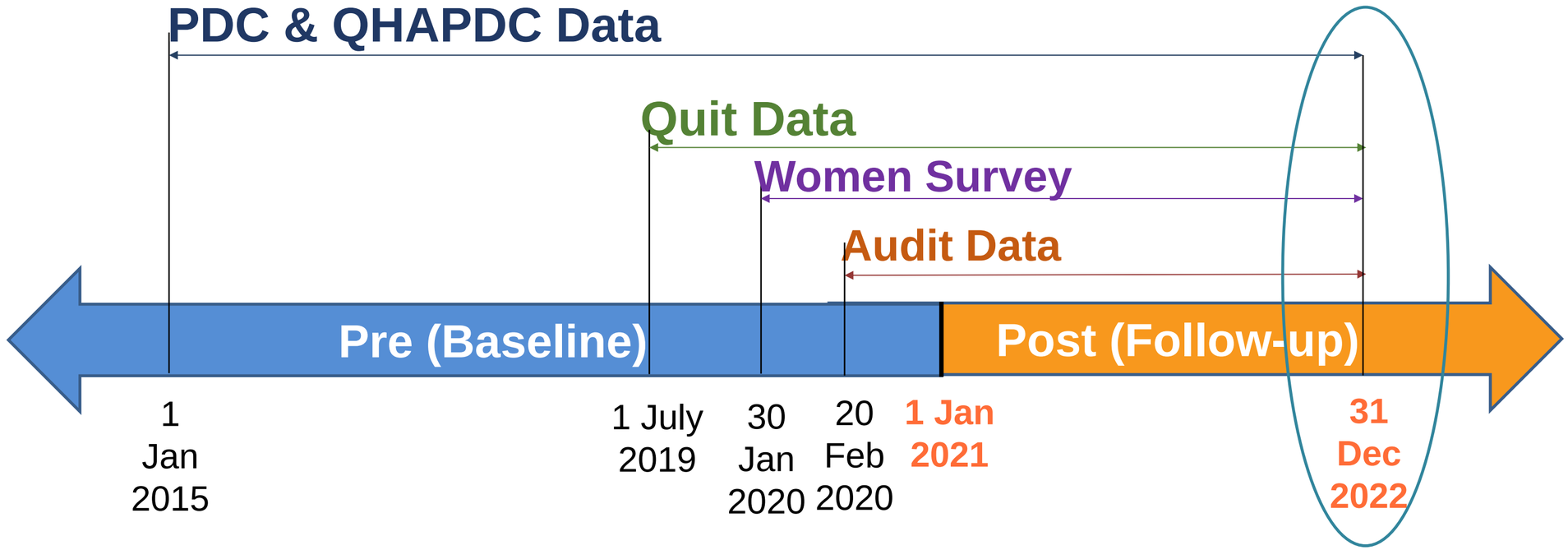
Time frame for different data used in SBB project



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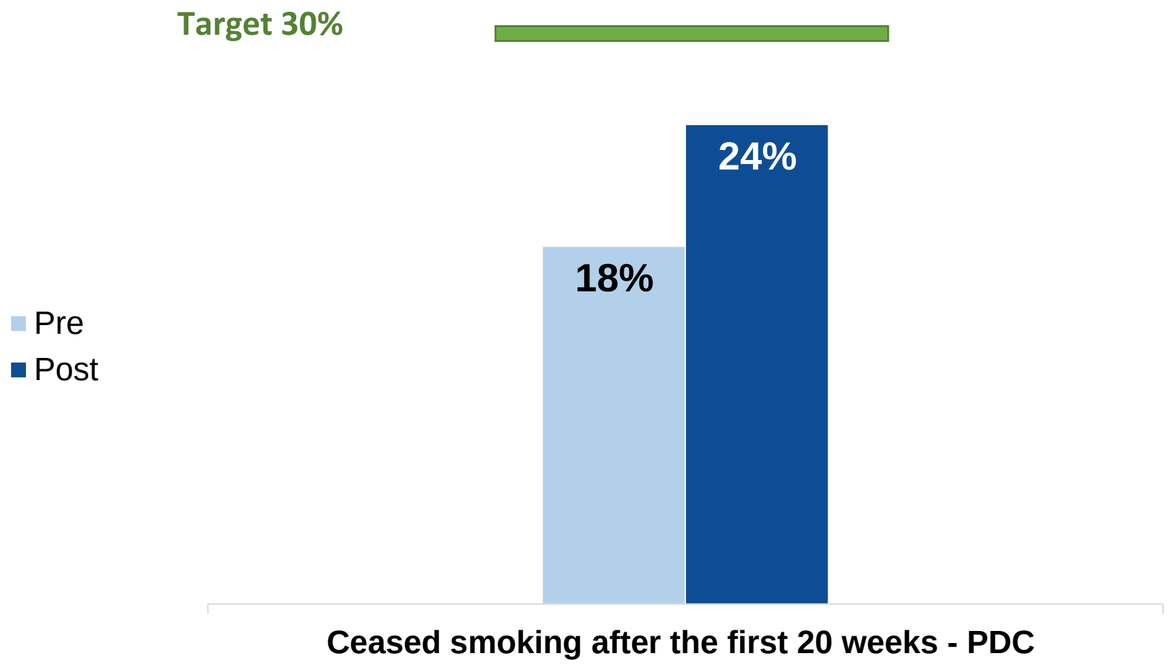
Element 1: Smoking cessation support:

Rate of smoking cessation after the first 20 weeks of pregnancy

(among women who reported smoking in the first 20 weeks of pregnancy – PDC)



p<0.0001

	Pre	Post	*p-value*
Indigenous	12%	**16%**	***<0.0001***
Non-Indigenous	20%	**27%**	***<0.0001***

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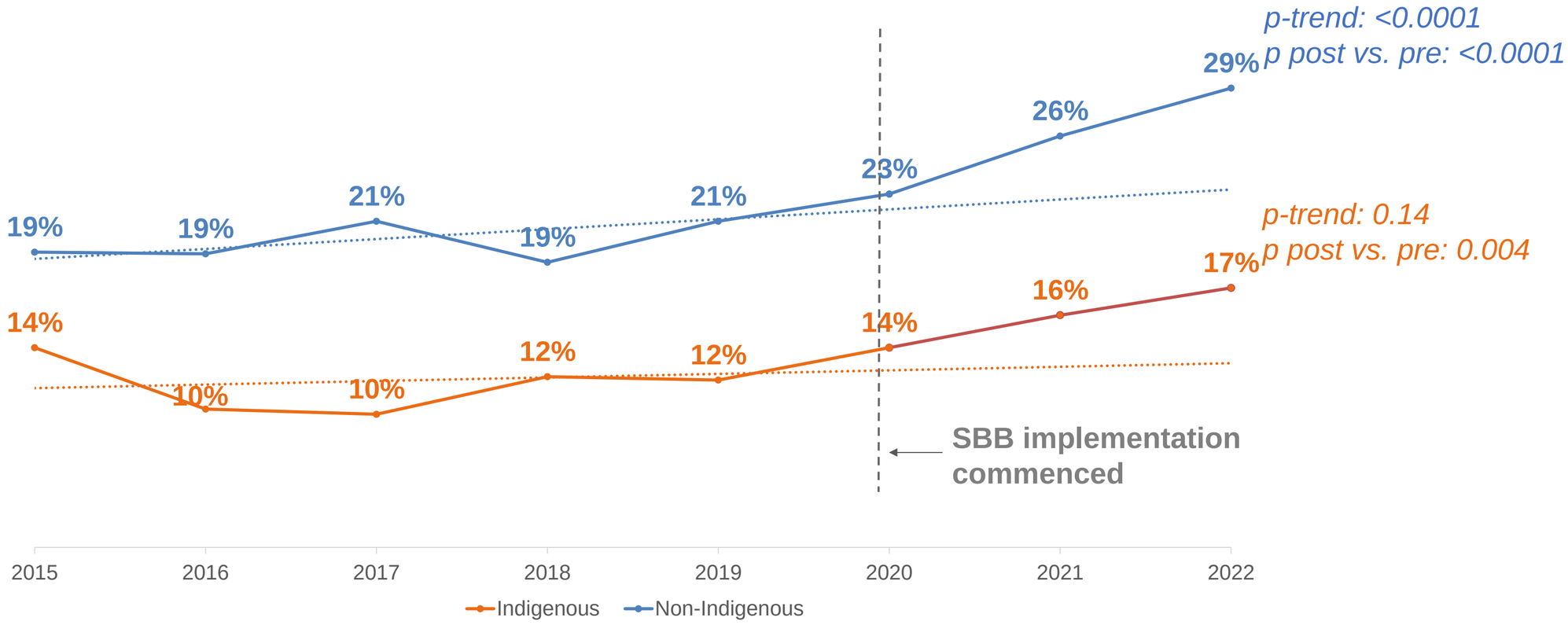

p values for trend from Wald test based on parameter estimate and SE from logistic regression for poisson distribution

Comparison between groups. p values from Wald test based on parameter estimate and SE from logistic regression for poisson distribution

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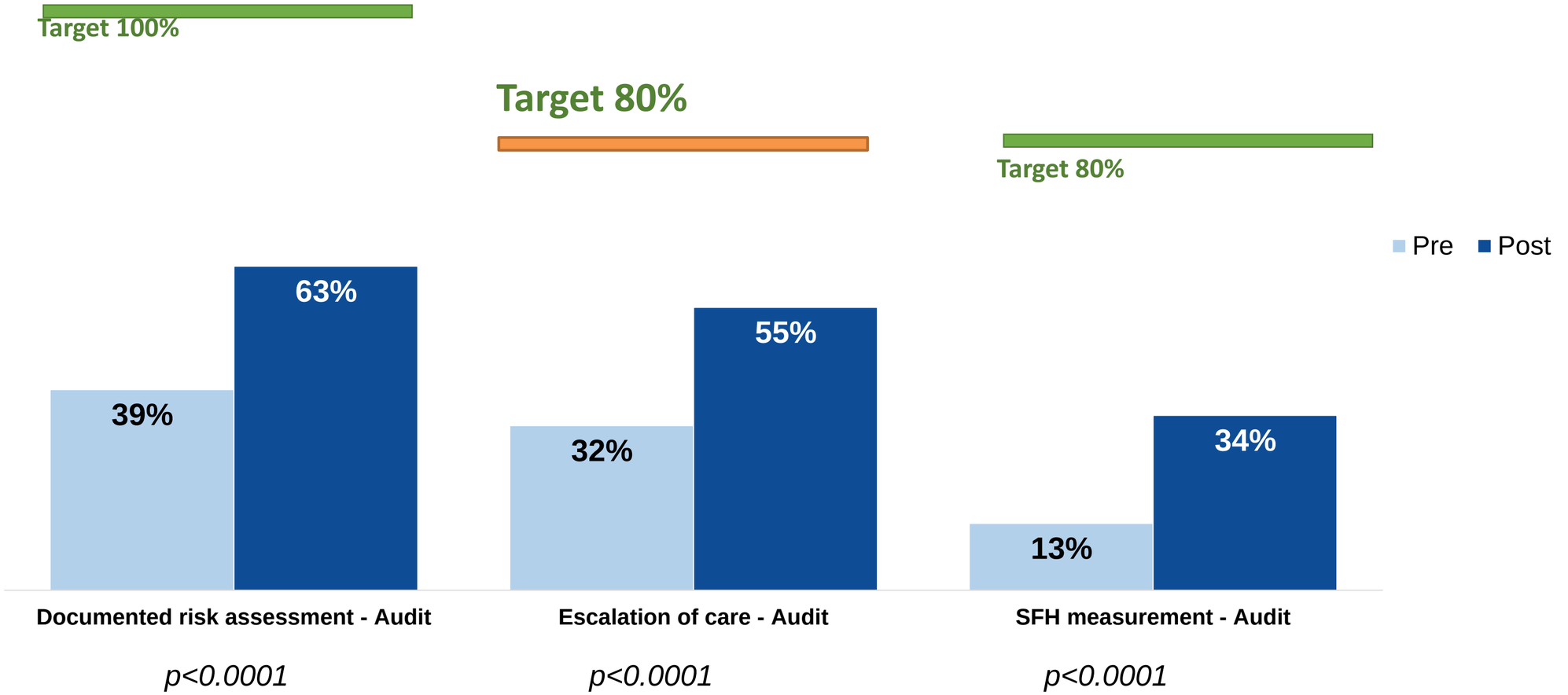
Element 2: Improved detection & management of impaired fetal growth



p-values from Chi Squared test

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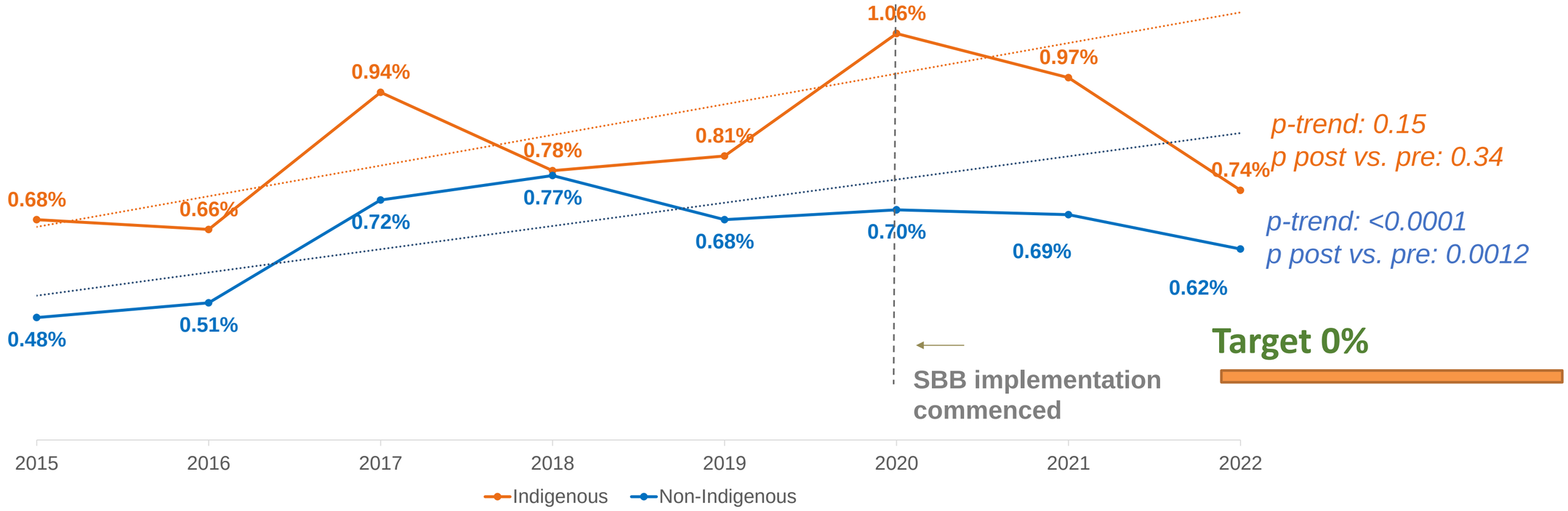
Element 2: Planned births for suspected FGR (false positive FGR) in all singleton births at ≥37 weeks - PDC

[Adjusted OR (95% CI): 0.77 (0.67, 0.89)]



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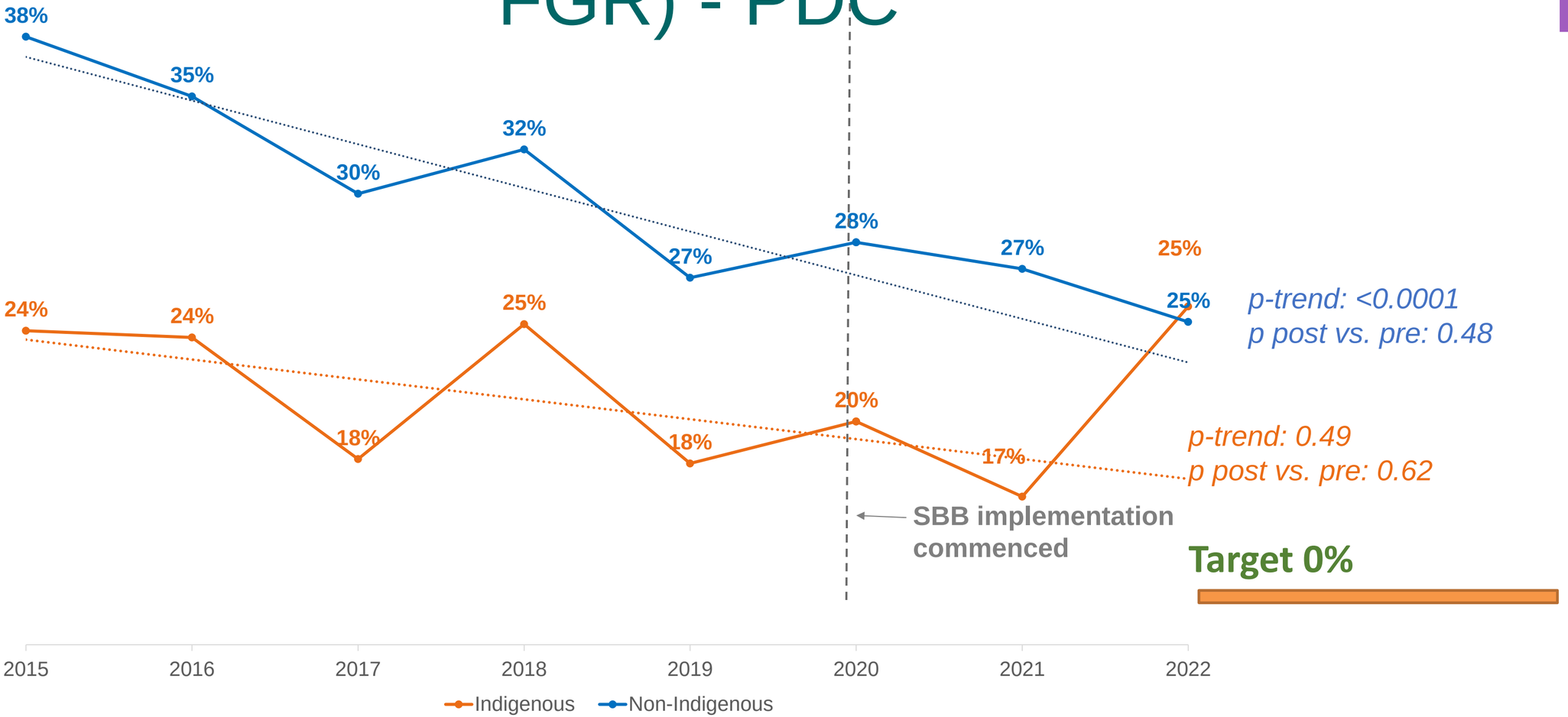
Element 2: Undetected severe FGR babies (missed FGR) - PDC



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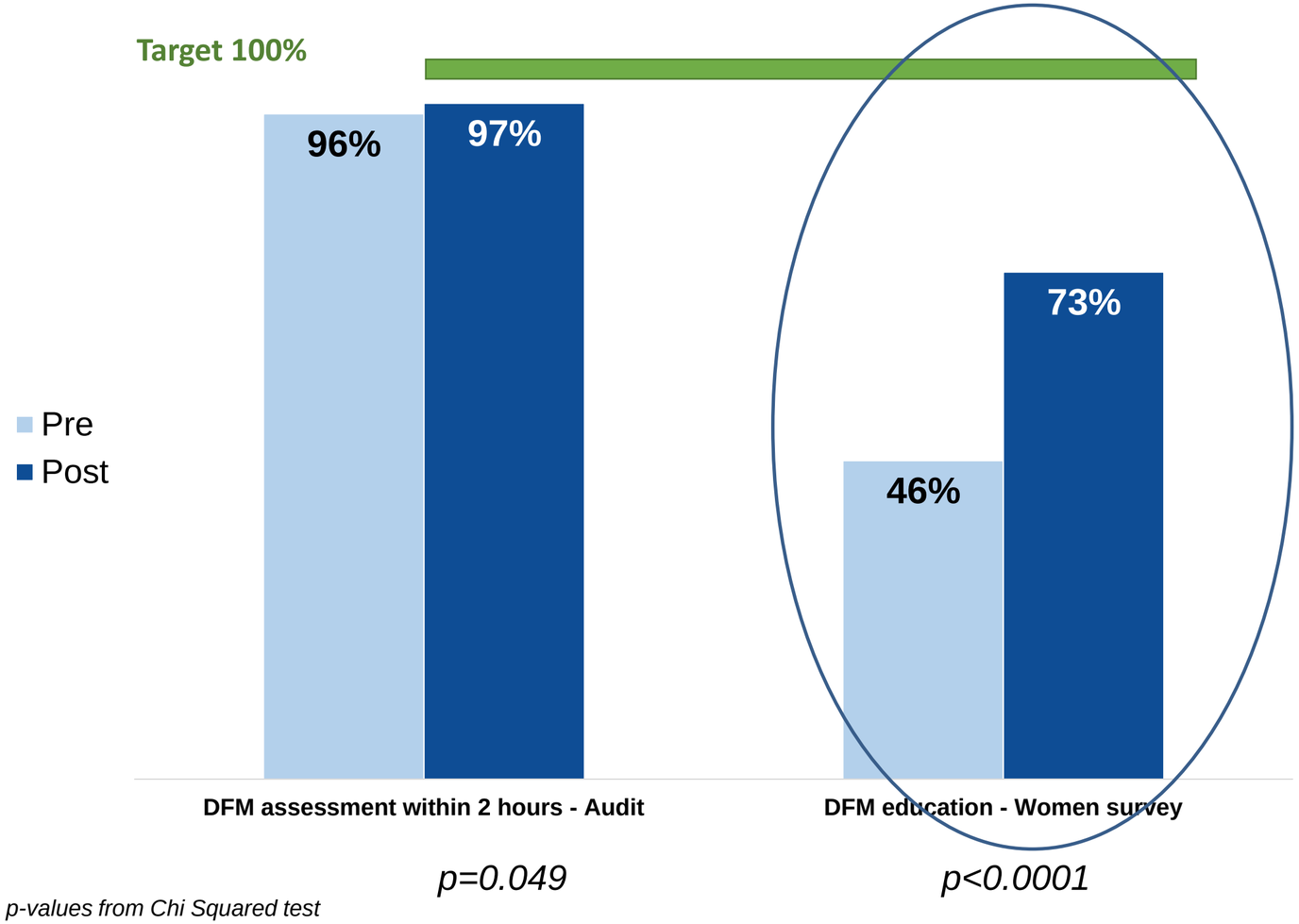
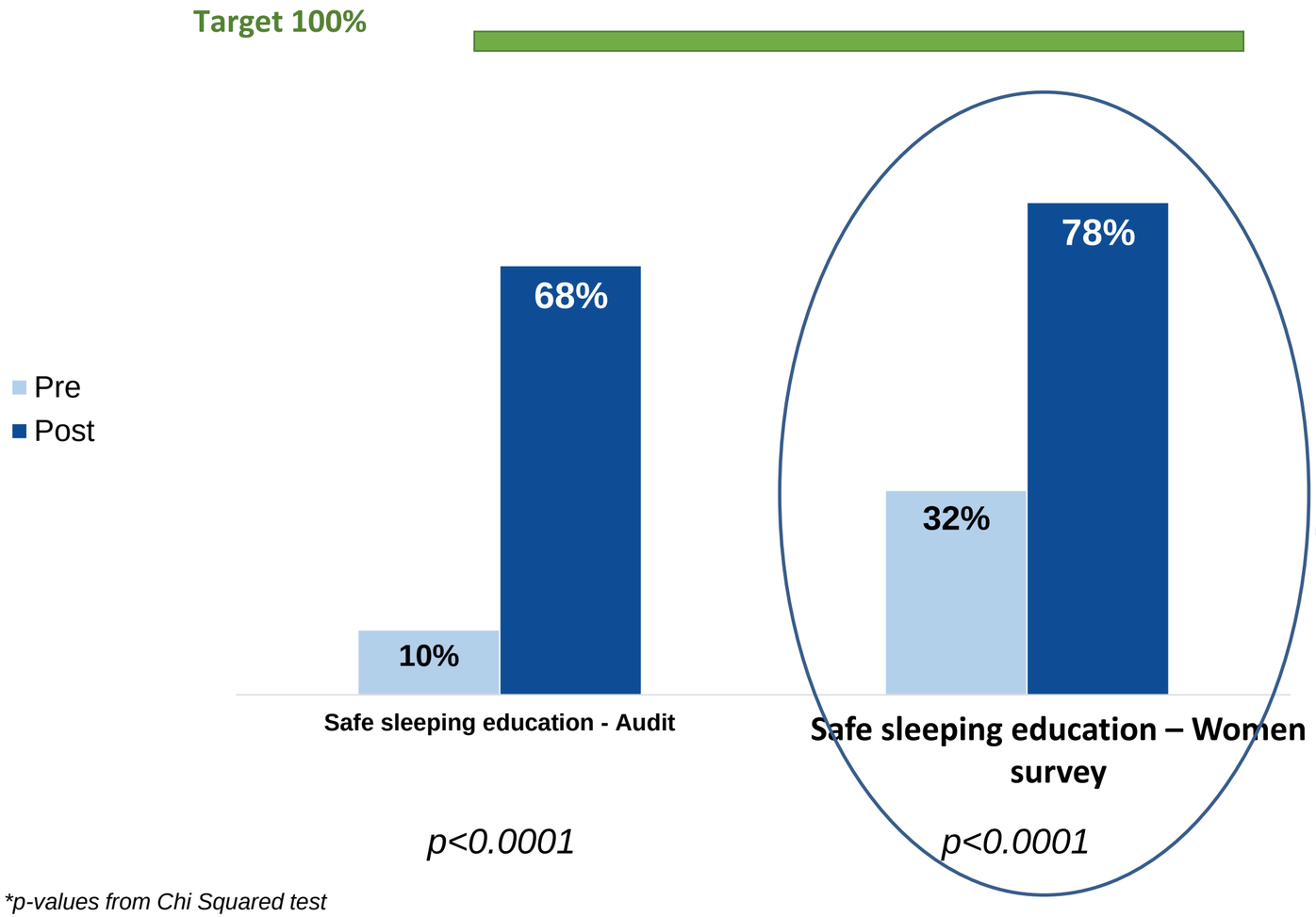
Element 3: Increasing awareness & management of women with decreased fetal movements (DFM)



p-values from Chi Squared test

DFM education (women survey)	**Pre**	**Post**	*p-value*
Indigenous	43%	**72%**	***0.017***
Non-Indigenous	46%	**73%**	***< 0.0001***

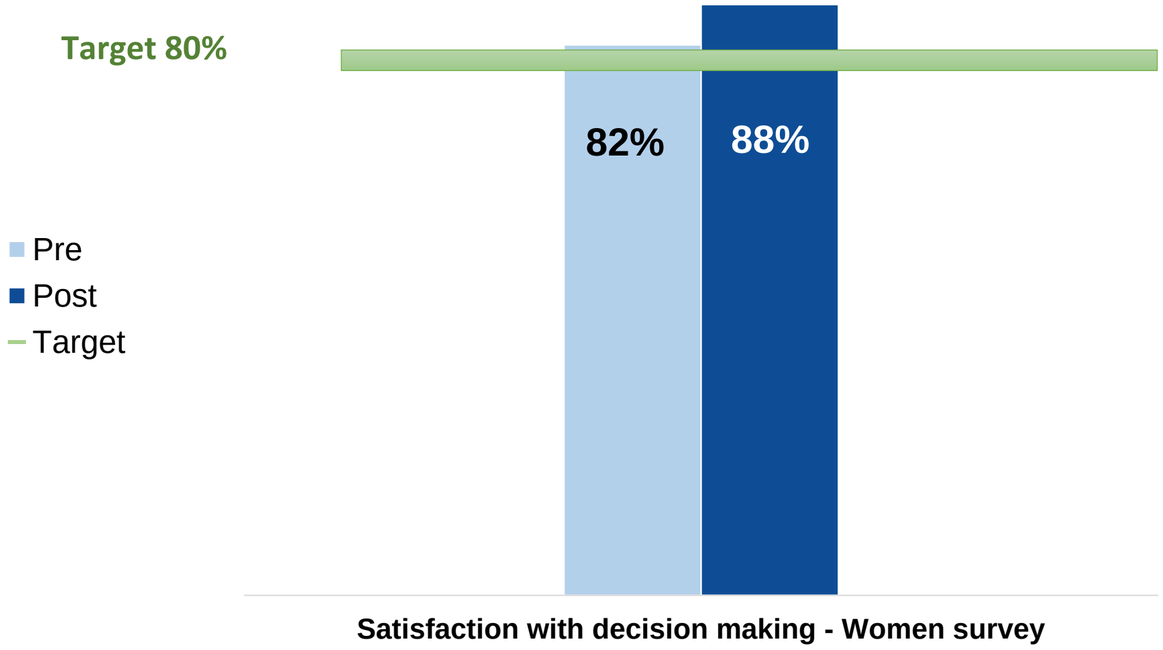
Element 4: Provision of maternal safe sleeping advice



Safe sleeping education – Women survey	Pre	Post	*p-value**
Indigenous	19%	**72%**	***< 0.0001*** **
Non-Indigenous	33%	**79%**	***< 0.0001***

**p-values from Chi Squared test*
***p-value from Fisher exact test*

Element 5:
Improved decision making around timing of birth for women with risk factors

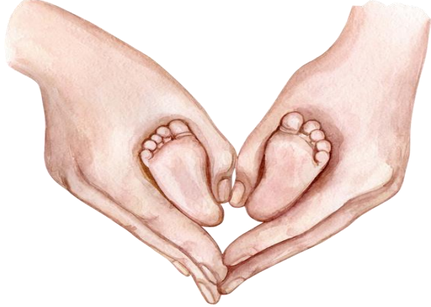


p=0.01

Satisfaction with decision making - women survey	Pre	Post	*p-value*
Indigenous	81%	91%	*0.25***
Non-Indigenous	82%	**88%**	***0.02***

p-values from Chi Squared test
***p-value from Fisher exact test*

No adverse impact on balancing measures



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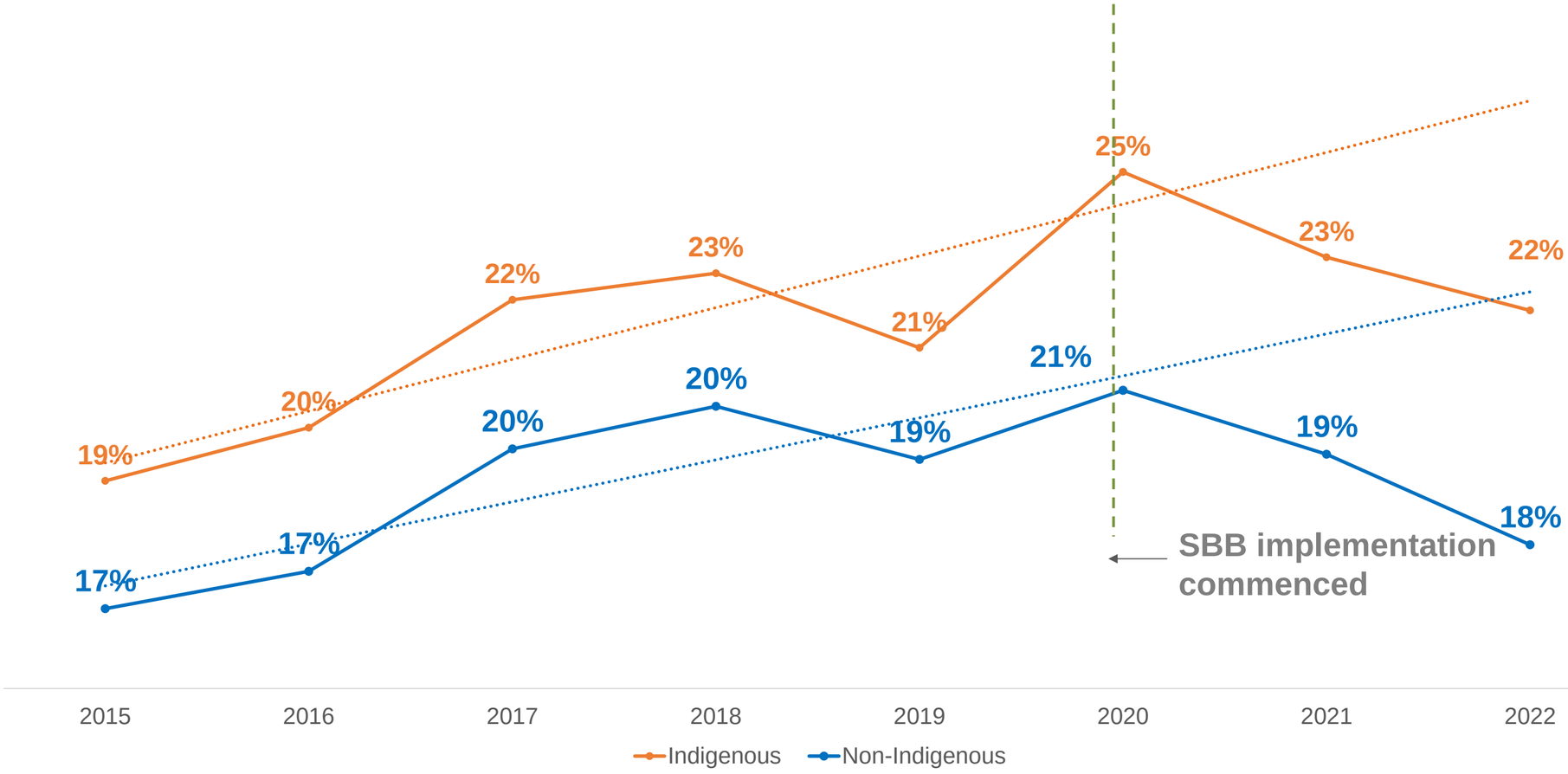
Induction of labour (IOL) or elective caesarean sections before 39 weeks with singleton pregnancy



p-trend: <0.0001
p post vs. pre: 0.003

p-trend: <0.0001
p post vs. pre: <0.0001

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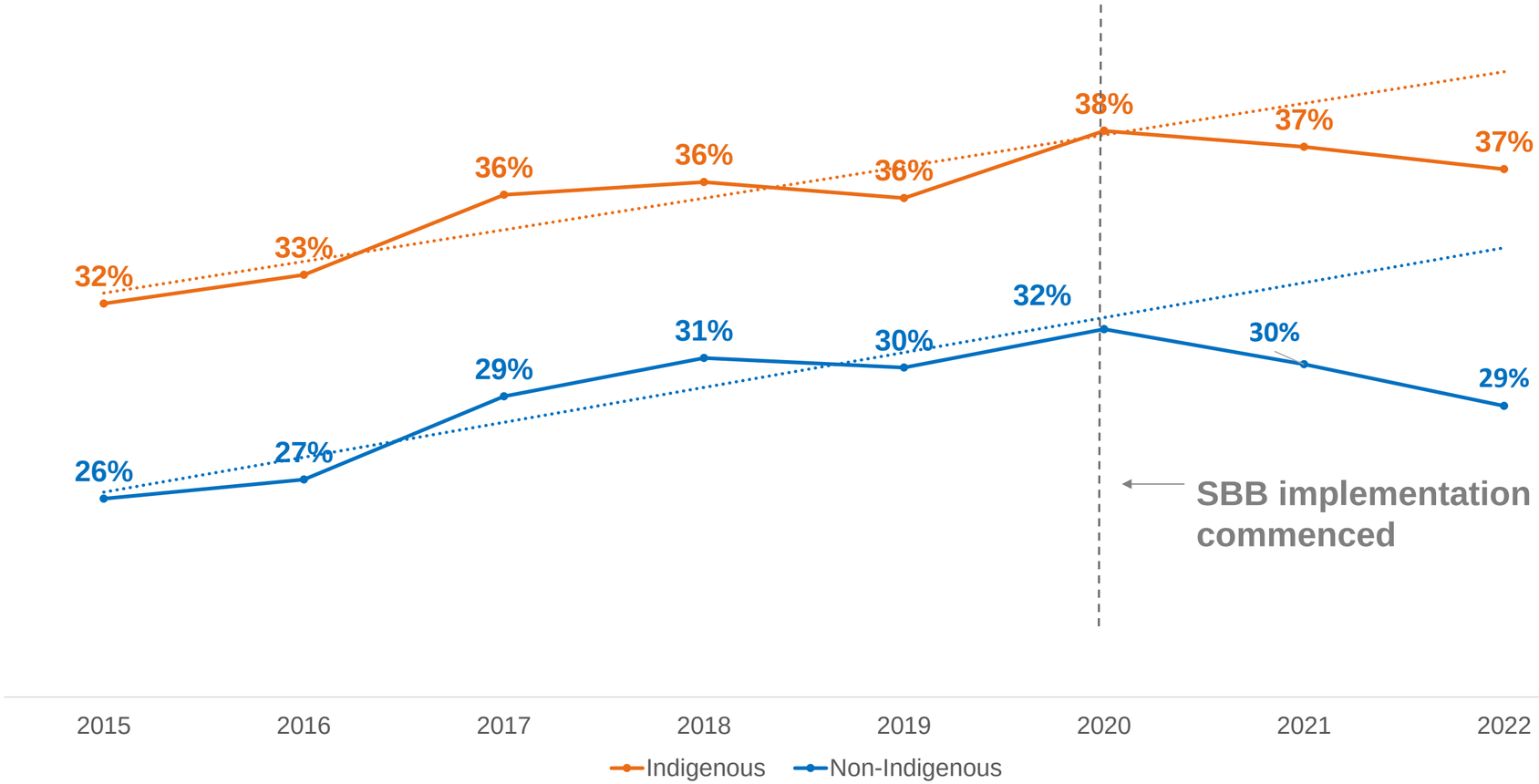
Early term births (between 37 & 38+6 weeks)



p-trend: <0.0001
p post vs. pre: 0.08

p-trend: <0.0001
p post vs. pre: <0.0001

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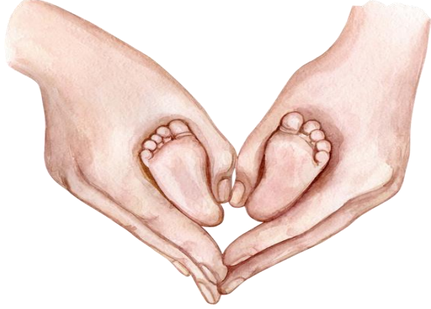

Stillbirths – rate per 1000 births

	Pre	Post
All	2.1	2.1
Indigenous	3.5	3.7
Non-Indigenous	2.0	2.0

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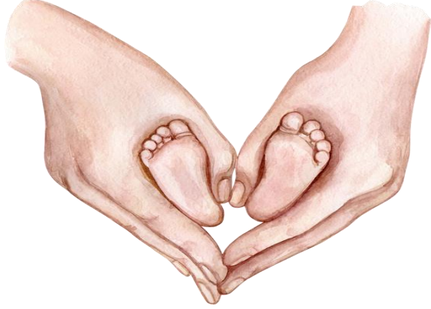
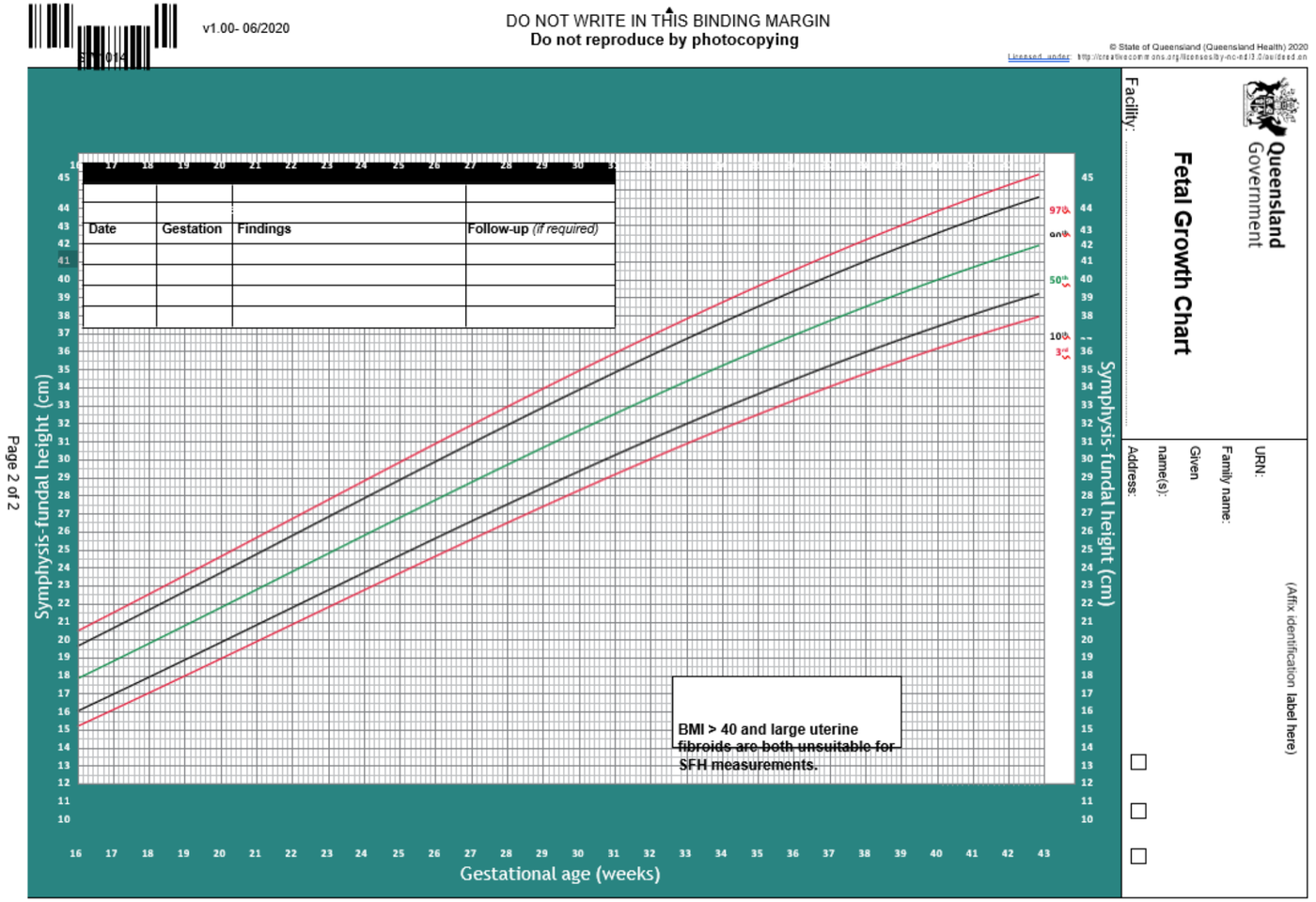
Standardisation & Sustainability





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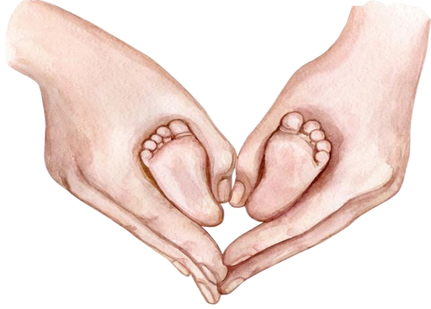
Standardisation & Sustainability



Metro North Hospital and Health Service *Putting people first*

Caboolture Hospital – Womens, Childrens and Family Services

Guideline

Effective from: June 2020
Review date: June 2023

Standardised Fetal Growth Chart, Use of and Referral Pathway - 005436

NSQHS STANDARDS 5.Comprehensive Care 6.Recognising and Responding to Acute Deterioration

Background

Assessment of fetal growth using fundal height remains an important first level screening tool during routine antenatal care for detection of abnormal fetal growth (Papageorghiou et al., 2016).

Plotting fundal height measurements and estimated fetal weights (EFW) provides a visual aid in the assessment of fetal growth trajectory. Deviation on the normal growth curve prompts timely consultation, escalation and referral for ultrasound scan and follow up.

A fundal height or EFW that deviates on a normal growth curve could indicate conditions such as:

- small for gestational age, fetal growth restriction or oligohydramnios
- large for gestational age, fetal macrosomia or polyhydramnios.

(RANZCOG, 2018) recommends serial measurement of fundal height at each antenatal appointment from 24 weeks of pregnancy.

Caboolture Hospital Maternity Services recommends that all women, at each visit from 28 weeks, should have their level of care reviewed and documented.

Purpose and intent

This document outlines the process for fetal growth measurement (fundal height and estimated fetal weight) and pathways for referral to optimise the detection and timely review of abnormal fetal growth. This is undertaken by the utilisation of the:

- *Caboolture Hospital Fetal Growth Restriction (FGR) Care Pathway (Appendix 2)*
- *Standardised Growth Chart Referral Pathway*. (Attachment 3)
- *Standardised Fetal Growth Chart - Fundal Height Chart - MR A 10820 (page1)* (Attachment 4)
- *Standardised Fetal Growth Chart – Fetal Weight chart - MR A 10820 (page 2)* (Attachment 4)

Scope and target audience

This document applies to all Caboolture Hospital clinical staff (permanent, temporary, casual and agency), students, and privately practicing midwives (PPM).

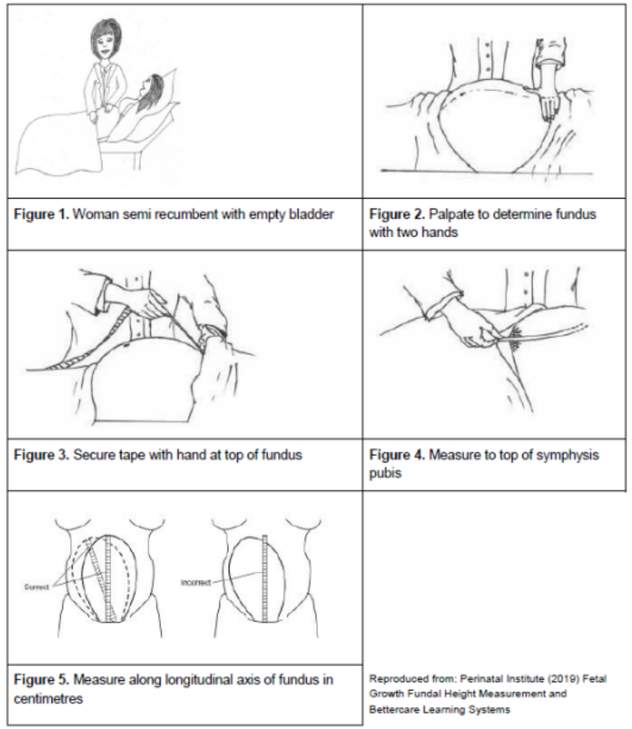


Figure 1. Woman semi recumbent with empty bladder

Figure 2. Palpate to determine fundus with two hands

Figure 3. Secure tape with hand at top of fundus

Figure 4. Measure to top of symphysis pubis

Figure 5. Measure along longitudinal axis of fundus in centimetres

Reproduced from: Perinatal Institute (2019) Fetal Growth Fundal Height Measurement and Bettercare Learning Systems

Exclusion

All women who have an obstetric ultrasound scan require estimated fetal weight to be recorded on the *Standardised Fetal Growth Chart (MRA 10820)* - fetal weight chart (page 2) by the medical officer or RM reviewing this scan report.
Refer as per *Standardised Growth Chart Referral Pathway* (Attachment 3).

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Standardisation & Sustainability

eLearning

Safer Baby Bundle

IMPROVE
IMproving Perinatal Mortality Review and Outcomes Via Education

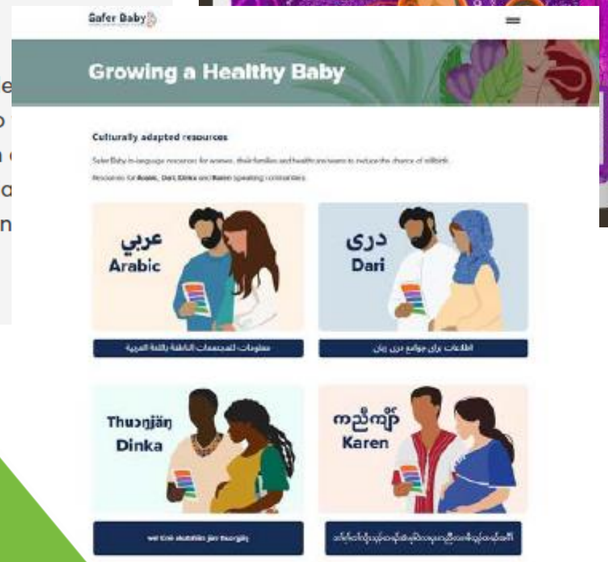
Safer Baby Bundle eLearning module

The Safer Baby Bundle module provides evidence based information for maternity health care providers on the 5 elements of the bundle: Smoking Cessation, Fetal Growth Restriction (FGR), Decreased Fetal Movements (DFM), Side Sleeping and Timing of Birth.

START MODULE

IMPROVE eLearning module

IMPROVE - This is a training package of six courses and is de
support maternity healthcare professionals in responding to
have experienced stillbirth, and gain crucial learnings. Each
approximately 20 minutes to complete and provides essentia
obstetricians, midwives, nurses, general practitioners and an



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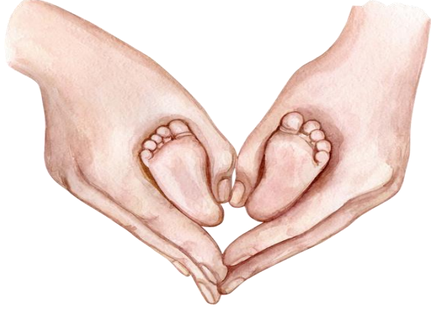

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Gold Coast Health

PREGNANCY RISK ASSESSMENT

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Age: G: P: EDD: Gestational age today: ☐ Singleton ☐ Multiple

Current Model of Care: WOBA number: GP Details:

OBSTETRIC RISK FACTORS, MEDICAL / MENTAL HEALTH CONDITIONS, MEDICATIONS, ABNORMAL INVESTIGATIONS:

☐ Yes ☐ No – If Yes, please document below, consult ACM Referral Guidelines & **REFER TO CHART REVIEW CLINIC**

RISK FACTORS FOR PERINEAL TEAR

- ☐ Previous 3rd or 4th degree tear
- ☐ Nulliparous AND from South East Asia

→ **Management**
- REFER TO CHART REVIEW CLINIC
- USS and chart review at 36 weeks

RISK FACTORS FOR STILLBIRTH

LOW RISK

No FGR / Stillbirth risk factors identified
- ☐ More than 50% of FGR cases occur in women with NO identifiable risk factor

→ **Management**
- ☐ Perform standardised serial SFH measurements at each antenatal visit from 24 weeks gestation and follow existing guidelines

MODERATE RISK

Risk factors for FGR / Stillbirth identified

MINOR RISK FACTORS
- ☐ Age ≥35 years and nulliparous
- ☐ IVF
- ☐ BMI >30
- ☐ Alcohol, Substance Use, Smoking
- ☐ ATSI, pacific, African or South Asian ethnicity
- ☐ No / poor antenatal care

MAJOR RISK FACTORS
- ☐ Age ≥40 years and nulliparous
- ☐ Previous late FGR / SGA (>32 weeks)
- ☐ Papp A ≤0.4 MoM

→ **Management**
- ☐ **1 minor risk factor:**

Routine care with SFH measurements *(if continued smoking / substance abuse or BMI >30 then consider USS at 28 – 30 + 34 – 36 wks and REFER TO CHART REVIEW CLINIC)*
- ☐ **2 x minor risk factors:**

Consider 1 – 2 x third trimester ultrasounds after 28 weeks. **REFER TO CHART REVIEW CLINIC**
- ☐ **3 or more minor RF's or 1 major risk factor**
  - Consider 2 – 3 third trimester ultrasounds from 28 weeks.
  - Commence low dose Aspirin *(100-150mg nocte)* prior to 16 weeks and continue to 36 weeks. **REFER TO CHART REVIEW CLINIC.**
  - If pregnancy uncomplicated consider IOL from 39 weeks

Antenatal Complications
- ☐ Suspected FGR / SGA by SFH or USS *(e.g. slow growth, static growth, <10th centile)*
- ☐ Pre-eclampsia
- ☐ Antepartum haemorrhage
- ☐ Congenital infection

→ **Management**
- REFER TO CHART REVIEW CLINIC
- Individualise management
- Consider uterine artery doppler at 20 - 24 weeks and 2 – 4 weekly USS from 24 weeks

Unsuitable for SFH measurements
- ☐ BMI ≥40
- ☐ Large uterine fibroids

→ **Management**
- REFER TO CHART REVIEW CLINIC
- 4 weekly USS's from 24 weeks
- If pregnancy uncomplicated consider from IOL 39 weeks

HIGH RISK OF EARLY FGR

High risk of early FGR
- ☐ Previously early *(<32 weeks)* FGR / SGA and / or pre-eclampsia
- ☐ Previous stillbirth with FGR / SGA
- ☐ Maternal medical conditions e.g:
  - Antiphospholipid antibody syndrome
  - Renal impairment
  - Chronic hypertension
  - Diabetes with vascular disease

→ **Management**
- REFER TO CHART REVIEW CLINIC
- Consider Uterine Artery Doppler at 20 – 24 weeks
- 2 – 4 weekly growth scans from 24 weeks
- Recommend dose aspirin *(100 – 150 mg nocte)* to commence prior to 16 weeks gestation and continue to 36 weeks
- Timing of birth according to sMFM guidance

ACTIONS TAKEN:

☐ Nil referral required ☐ **REFERRED TO CHART REVIEW CLINIC** via email: GPLOmidwife@health.qld.gov.au

Discussed: ☐ Smoking ☐ Side sleeping ☐ Fetal movements ☐ Fetal growth ☐ Timing of birth / Risks of stillbirth

Clinician name (print): Designation:

Signature: Date:

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Acknowledgement: Centre of Research Excellence in Stillbirth, Western Pacific Regional Office of the International Stillbirth Alliance, Coordinating Centre, PSANZ Stillbirth & Neonatal Death Alliance (SANDA)

Queensland Government

Safer Baby Bundle Risk Assessment

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Signature Log *Every person documenting in this form must supply a sample of their initials and signature below.*

Initials	Signature	Name	Designation	Initials	Signature	Name	Designation

Safer Baby Bundle

Element 1	Element 2	Element 3	Element 4	Element 5
Smoking Cessation (Refer to QUIT Smoking Cessation Care Pathway)	Fetal Growth (Refer to FGR flowchart)	Fetal Movement (Refer to DDH DFM flowchart)	Side Sleeping (Refer to Sleep on your side when baby inside brochure)	Timing of Birth (Refer to Every Week Counts brochure)

Risk factors for Stillbirth Prevention *(tick)*

☐ Maternal Age > 35	☐ No / limited antenatal care
☐ BMI > 30	☐ Previous stillbirth
☐ Maternal smoking	☐ Pre-existing diabetes
☐ Nulliparity	☐ Pre-existing hypertension
☐ Artificial Reproductive Technology	☐ Pre-eclampsia
☐ Alcohol/drug use	☐ Small for gestational age (< 10th centile)
☐ Aboriginal and Torres Strait Islander, Pacific, African and South Asian ethnicities	☐ Decreased fetal movement presentation
Initial/Date:	

LEVEL 2 SURVEILLANCE:	LEVEL 3 SURVEILLANCE:
Risk factors for FGR	**Risk factors for FGR**
☐ Age ≥ 40 years or ≤ 20	☐ Previous early (< 32 weeks) FGR/SGA and/or pre-eclampsia
☐ Substance use during pregnancy: smoking, drugs	☐ High risk first trimester pre-eclampsia screening result in this pregnancy
☐ IVF singleton pregnancy	☐ Previous stillbirth with FGR/SGA
☐ Limited antenatal care	Maternal medical conditions, eg:
☐ Booking BMI ≥ 35 or ≤ 18	☐ Antiphospholipid antibody syndrome
☐ Previous late (> 32 weeks) FGR/SGA	☐ Renal impairment
☐ PaPP A < 0.4 MoM	☐ Chronic hypertension
	☐ Diabetes with vascular disease
Initial/Date:	

FGR Level Surveillance		Initial/Date:
Booking	☐ L1 ☐ L2 ☐ L3	
28 weeks	☐ L1 ☐ L2 ☐ L3	
36 weeks	☐ L1 ☐ L2 ☐ L3	

Side sleeping discussion and pamphlet provided		
Booking	☐ Initial/Date	
20 weeks	☐ Initial/Date	
24 weeks	☐ Initial/Date	

Decreased fetal movement episodes	Initial/Date:

Brochures provided	Initial/date:
Fetal Movement	
Safer Baby	

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Safer Baby Bundle Risk Assessment

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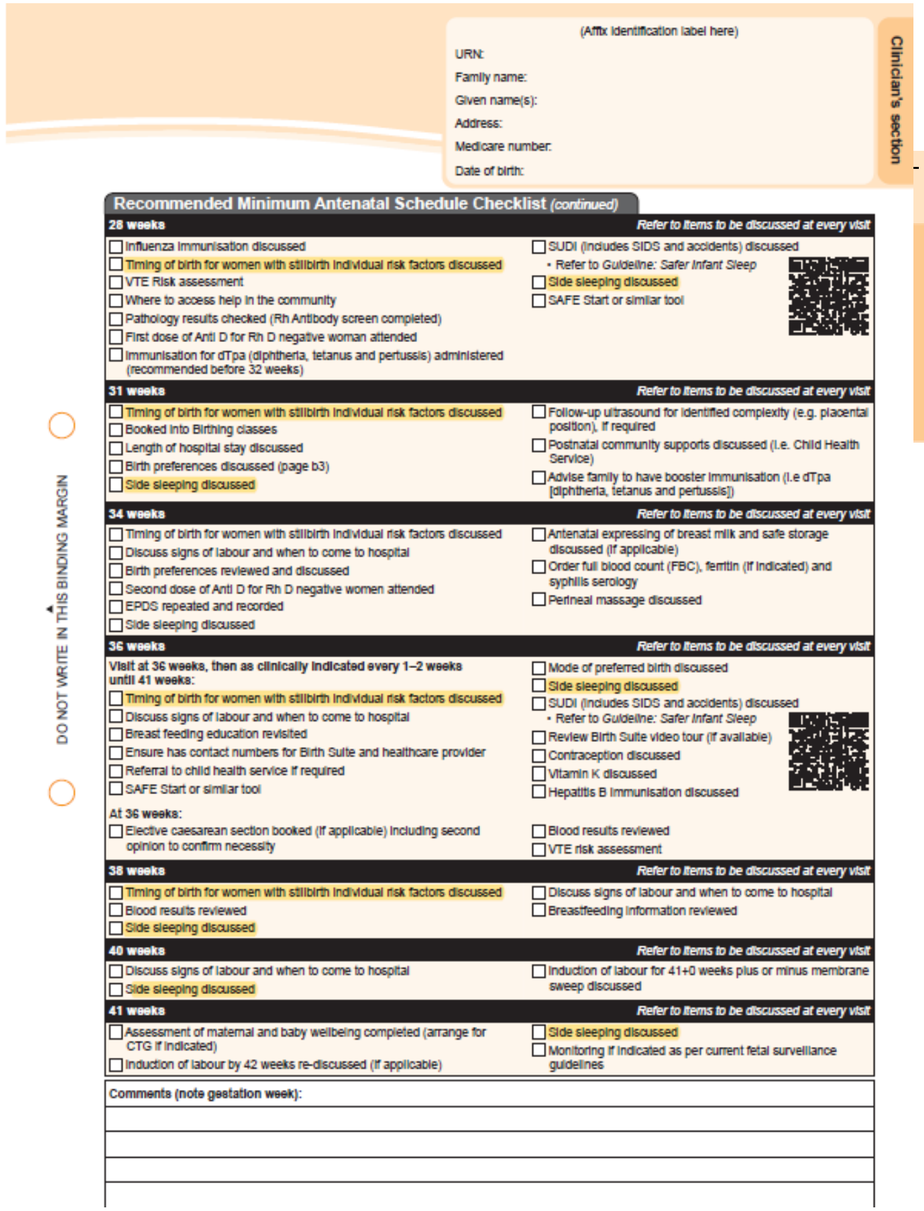
Standardisation & Sustainability



(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Medicare number:
Date of birth:

Clinician's section

Recommended Minimum Antenatal Schedule Checklist *(continued)*

26 weeks — *Refer to items to be discussed at every visit*

- ☐ Influenza immunisation discussed
- ☐ Timing of birth for women with stillbirth individual risk factors discussed
- ☐ VTE Risk assessment
- ☐ Where to access help in the community
- ☐ Pathology results checked (Rh Antibody screen completed)
- ☐ First dose of Anti D for Rh D negative woman attended
- ☐ Immunisation for dTpa (diphtheria, tetanus and pertussis) administered (recommended before 32 weeks)
- ☐ SUDI (includes SIDS and accidents) discussed
  - Refer to *Guideline: Safer Infant Sleep*
- ☐ Side sleeping discussed
- ☐ SAFE Start or similar tool

31 weeks — *Refer to items to be discussed at every visit*

- ☐ Timing of birth for women with stillbirth individual risk factors discussed
- ☐ Booked into Birthing classes
- ☐ Length of hospital stay discussed
- ☐ Birth preferences discussed (page b3)
- ☐ Side sleeping discussed
- ☐ Follow-up ultrasound for identified complexity (e.g. placental position), if required
- ☐ Postnatal community supports discussed (i.e. Child Health Service)
- ☐ Advise family to have booster immunisation (i.e dTpa [diphtheria, tetanus and pertussis])

34 weeks — *Refer to items to be discussed at every visit*

- ☐ Timing of birth for women with stillbirth individual risk factors discussed
- ☐ Discuss signs of labour and when to come to hospital
- ☐ Birth preferences reviewed and discussed
- ☐ Second dose of Anti D for Rh D negative women attended
- ☐ EPDS repeated and recorded
- ☐ Side sleeping discussed
- ☐ Antenatal expressing of breast milk and safe storage discussed (if applicable)
- ☐ Order full blood count (FBC), ferritin (if indicated) and syphilis serology
- ☐ Perineal massage discussed

36 weeks — *Refer to items to be discussed at every visit*

Visit at 36 weeks, then as clinically indicated every 1–2 weeks until 41 weeks:

- ☐ Timing of birth for women with stillbirth individual risk factors discussed
- ☐ Discuss signs of labour and when to come to hospital
- ☐ Breast feeding education revisited
- ☐ Ensure has contact numbers for Birth Suite and healthcare provider
- ☐ Referral to child health service if required
- ☐ SAFE Start or similar tool
- ☐ Mode of preferred birth discussed
- ☐ Side sleeping discussed
- ☐ SUDI (includes SIDS and accidents) discussed
  - Refer to *Guideline: Safer Infant Sleep*
- ☐ Review Birth Suite video tour (if available)
- ☐ Contraception discussed
- ☐ Vitamin K discussed
- ☐ Hepatitis B immunisation discussed

At 36 weeks:

- ☐ Elective caesarean section booked (if applicable) including second opinion to confirm necessity
- ☐ Blood results reviewed
- ☐ VTE risk assessment

38 weeks — *Refer to items to be discussed at every visit*

- ☐ Timing of birth for women with stillbirth individual risk factors discussed
- ☐ Blood results reviewed
- ☐ Side sleeping discussed
- ☐ Discuss signs of labour and when to come to hospital
- ☐ Breastfeeding information reviewed

40 weeks — *Refer to items to be discussed at every visit*

- ☐ Discuss signs of labour and when to come to hospital
- ☐ Side sleeping discussed
- ☐ Induction of labour for 41+0 weeks plus or minus membrane sweep discussed

41 weeks — *Refer to items to be discussed at every visit*

- ☐ Assessment of maternal and baby wellbeing completed (arrange for CTG if indicated)
- ☐ Induction of labour by 42 weeks re-discussed (if applicable)
- ☐ Side sleeping discussed
- ☐ Monitoring if indicated as per current fetal surveillance guidelines

Comments (note gestation week):

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Clinician's section

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Medicare number:
Date of birth:

Best estimate date of birth: / /

Gravida:	Parity:	Blood group:

Visit Notes *(1 of 5)*

All hospital staff document any variances in progress notes

Date / Time	BP (seated) Cuff size	Weeks / gestation calc	Fundal height (cm)	Presentation	Descent / Fifths above brim	FHR	Fetal movement	Liquor	Weight (kg)	Urinalysis (U/A) (if required)	Next visit

Notes:

Safer Baby Bundle discussed: ☐ Fetal growth chart ☐ Safe maternal sleep position ☐ Quitting vaping ☐ Quitting tobacco ☐ Cigarettes p/day: ___

☐ Advice weight gain ☐ Nutrition ☐ Activity — Alcohol, other brief intervention offered: ☐ Yes ☐ N/A ☐ Declined

Registered interpreter present? ☐ Yes ☐ No — Aboriginal and Torres Strait Islander Health Worker present? ☐ Yes ☐ No

Maternity care provider name:	Designation:	Signature:

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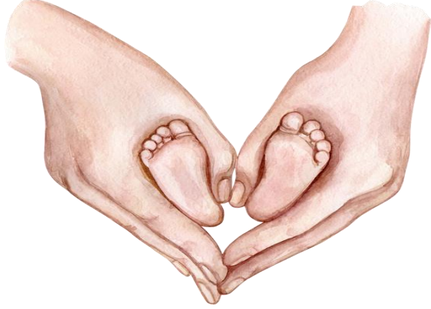

Fetal Growth Restriction Care Pathway

Please follow local guidelines relating to risk factors and surveillance levels

No risk factors for FGR identified

More than 50% of FGR cases occur in women with NO identifiable risk factors

Level 1 Surveillence

- ☐ SFH measurement from 24 weeks gestation
- ☐ Plot measurement on SFH graph
- ☐ Ultrasound as clinically indicated

Level 2 FGR Risk Factors

- ☐ None
- ☐ Age > 40 years or age < 20 years
- ☐ IVF Singleton pregnancy
- ☐ BMI > 35 or BMI < 18
- ☐ Previous late FGR/SGA > 32weeks
- ☐ PaPP A < 0.4MoM
- ☐ Smoking or Substance use in pregnancy
- ☐ Limited antenatal care

Level 2 Surveillence

- ☐ Fetal growth USS 26-28 weeks gestation
- ☐ Plot measurem
- ☐ Fetal growth USS 34-36 weeks gestation
- ☐ Additional USS as clinically indicated
- ☐ SFH measurement from 24 weeks gestation

Level 3 FGR Risk Factors

- ☐ None
- ☐ Previous early FGR/SGA > 32weeks
- ☐ Previous early Pre-eclampsia > 32weeks
- ☐ 1st trimester pre-eclampsia this pregnancy
- ☐ Previous Stillbirth with FGR/SGA
- ☐ Maternal Antiphospholipid antibody syndrome
- ☐ Maternal Renal impairment
- ☐ Maternal Chronic hypertension
- ☐ Maternal Diabetes with Vascular disease

Level 3 Surveillence

- ☐ Fetal Growth USS 2-4 weeks from 24 weeks gestation
- ☐ Com

Decreased Fetal Movements

Fetal Movement Information discussed ○ Yes ○ No

Information Brochure provided ○ Yes ○ No

Side Sleeping

Side Sleeping Information discussed ○ Yes ○ No

Side Sleeping Brochure provided ○ Yes ○ No

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Questions?

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Thank you & further info

More Information

saferbabybundle@health.qld.gov.au

Stillbirth Centre of Research Excellence

stillbirthcre@mater.uq.edu.au

https://stillbirthcre.org.au/parents

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