

Stillbirth

Clinical Care Standard

The *Stillbirth Clinical Care Standard* aims to reduce unwarranted clinical variation in the prevention and investigation of stillbirth and reduce the number of women experiencing stillbirth, especially after 28 weeks gestation. It also aims to support best practice in bereavement care for parents following any perinatal loss, and in the care provided to women when planning for, and during, subsequent pregnancies.

The *Stillbirth Clinical Care Standard* contains 10 quality statements that describe the health care that should be provided to women who are pregnant or planning a pregnancy, from preconception to after a stillbirth occurs. It also addresses bereavement care for parents who have experienced any form of perinatal loss, regardless of gestational age, and care for future pregnancies.

It includes a set of indicators to support healthcare services to monitor how well they are implementing the care recommended in this clinical care standard and to support local quality improvement activities.

This information sheet describes what the quality statements mean for healthcare services and lists the indicators.

The definitions required to collect and calculate indicator data are specified online at meteor.aihw.gov.au/content/766607

Monitoring the implementation of this clinical care standard can help healthcare services to achieve actions within the [*National Safety and Quality Health Service \(NSQHS\) Standards*](#).

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.

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
- 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*](#). 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. 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 National Safety and Quality Primary and Community Healthcare Standards.



Cultural safety and equity

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.

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.

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*](#)). 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*](#).

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.



Cultural safety and equity

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.

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, which have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth, including Aboriginal and Torres Strait Islander women.

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.

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.

3 Stillbirth awareness and strategies to reduce risk

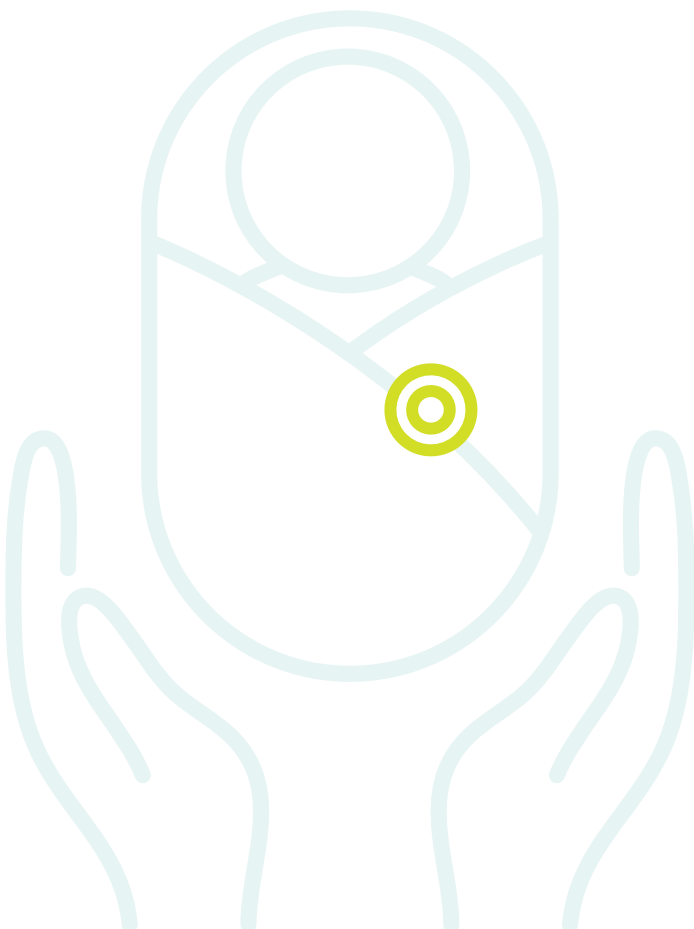
Early in pregnancy, a woman is informed about stillbirth as a potential outcome. Throughout the pregnancy, she is supported to adopt strategies that may reduce her risk of stillbirth, including smoking cessation, using a side going-to-sleep position from 28 weeks gestation and being aware of fetal movements.

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. 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.





Cultural safety and equity

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.

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.

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.

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.

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, second and third 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.

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.

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.

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.

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. These should be established according to the **Decreased Fetal Movement (DFM) Care Pathway**, 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
- 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 rate 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 tone 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 and the Parent-centred Communication in Obstetric Ultrasound Guidelines

- 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*
- 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** or a locally approved alternative, monitor its use and evaluate outcomes, including potential impacts on rates of early planned births.

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 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

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.

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 and the *Safer Baby Bundle educational program* on timing of birth for maternity care providers.

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.

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 who had a planned birth before 39 weeks gestation.

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.

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
- 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

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.

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.

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.

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*. The process should include:

- Using the PSANZ Classification System for Stillbirths and Neonatal Deaths 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
- 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.

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.

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.

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.

Healthcare services should establish and foster a commitment to delivering best-practice bereavement care following perinatal loss. 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* and *Sands Australian Principles of Bereavement Care*. These should address:

- 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. 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

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.

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.

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.

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.

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

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, including Aboriginal and Torres Strait Islander women.

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.

Questions?



Find out more about the *Stillbirth Clinical Care Standard* and other resources. Scan the QR code or use the link safetyandquality.gov.au/stillbirth-ccs.

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.