Manitoba Health

Manitoba Health supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Fetal Demise

Summary: An obstetrical patient was discovered to have a breech baby (feet down) on a routine prenatal visit. The patient's expected date of confinement (EDC) on the prenatal record placed the pregnancy at 39+ weeks gestation. The patient was admitted to hospital for an obstetrical assessment and a scheduled caesarean section was to occur that evening or the following morning for the breech position of the baby.

Upon reviewing the chart, it was noted that an ultrasound report on file had a different date for the EDC which was 2 weeks later, therefore the patient was assessed as being 37+ weeks gestation. The caesarean section was cancelled and the patient was discharged home to return the following week.

The patient returned 5 days later in labor with decreased fetal movement and no fetal heart rate was detected. The patient delivered a stillborn by caesarean section.

Keywords: Stillbirth, fetal demise.

This review is based on a single event.

Findings of the Review:

An obstetrical patient 39+ weeks gestation was admitted for a scheduled cesarean section for a breech presentation.

There was a discrepancy in the patient's EDC based on an ultrasound report performed at 22 weeks, placing the patient at 37+ weeks gestation not 39+ weeks gestation.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) Guidelines indicates that ultrasounds performed between 21 and 30 weeks are accurate plus or minus 2 weeks which would have placed the patient at 37- 41 weeks.

The patient was not in labor and was discharged home to return the following week for a scheduled caesarean section.

The patient returned 5 days later in labor with decreased fetal movement and no fetal heart rate was detected. The patient delivered a stillborn by caesarean section. An autopsy was declined.

System Learning:

There are no critical incident recommendations following the review. However, there is one suggestion to enhance patient safety.

All External Fetal Monitoring (EFM) strips are to be placed in an envelope/bag that is addressograph labeled and to be retained in the current inpatient chart. Once the patient is discharged, the EFM strip in the envelope/bag to be sent with the patient chart to Health Information Services (HIS).

***NOTE SUGGESTIONS DO NOT GET REPORTED TO MHSAL**