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2425-058

Patient Safety Learning Advisory

Patient Safety Event: Fetal Demise

Why was this a Critical Incident? Full term fetal or neonatal death or serious disability associated with labor and delivery while being cared for by a service delivery organization (SDO) meets the threshold of a reportable critical incident to Manitoba Health.

What happened in the incident? An obstetrical patient came in to the hospital in active labor. As labor progressed, fetal tachycardia was documented with inconsistent interventions and monitoring. The infant was delivered with no respiratory effort. Despite full resuscitative efforts, the infant died.

What is the Health Care System learning?

Monitoring of this laboring patient did not follow the "Fetal Health Surveillance in Labor Guideline":

- A 20-minute EFM strip was completed at admission and documented in the IPN as normal. After this initial strip, IA was performed to monitor FHR until SROM which showed meconium staining. At this point, for the remainder of the labor and delivery there was an indeterminate EFM tracing without the use of the Toco to monitor contractions.
- The external fetal monitoring (EFM) ultrasound was used for intermittent auscultation (IA) fetal heart rates when ultrasound dopplers were available.
- No maternal vital signs (VS) including maternal heart rate (HR) for comparison to fetal heart rate (FHR) were documented for 8 hours during the labor and delivery.
- Fetal scalp electrode monitoring was not implemented as an option when the EFM tracing was difficult to maintain with the laboring patient due to frequent position changes with contractions and pushing.
- Throughout the labor and delivery periods of fetal tachycardia was documented by IA and EFM ultrasound with no interventions documented.

Staffing/ patient ratios are below Society of Gynecologist Canada (SOGC) national standard of 1:1 nursing care for a laboring patient and 2:1 birthing standard.

What are the recommendations?

Implement revised obstetrical education which includes ongoing fetal health surveillance competency checks for all staff.

To complement education, consider additional obstetrical support for mentorship. (ie. Clinical Resource Nurse (CRN) specific to obstetrics).

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*SUGGESTIONS TO ENHANCE PATIENT SAFETY

The information and suggestion that follow were brought forward during the Critical Incident review. These factors did not contribute to the critical incident; however, the suggestions are being shared as opportunities for system improvement. This information will not be included in the Manitoba Health Patient Safety Learning Advisory but will be shared with the respective Senior Leaders. These suggestions are not intended for follow up reporting to Manitoba Health.

Remind staff where neonatal resuscitation kits and equipment for labor and delivery emergencies are stored.

Re-implement regular educational sessions which would including neonatal resuscitation simulations at the site.

Investigate how to modify the Infant warmer to have suction tubing secured while in use.

Keywords: Fetal Demise; Neonatal Death

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It's important that we can learn from safety events and make changes to improve the care we provide.