STANDARD OPERATING PROCEDURE

Indications for Placental Histology and Obstetric Clinical Follow-up

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VERSION 1.0	**REVIEW DATE:**

PURPOSE

The purpose of this Standard Operating Procedure (SOP) is to ensure that all staff understand the indications for placental histology and Obstetric Clinic Follow-Up.

OBJECTIVE

To outline indications for placental histopathology and Obstetric Clinical Follow-up

SCOPE

This guidance is relevant to following staff groups:

- All midwifery staff who work in maternity
- All medical staff working within the Obstetrics and Gynaecology team – Consultants, Middle Grades and Juniors
- All staff working to manage the patient pathway –Specialist Midwives, Consultants, Service Manager

COMPETENCIES

No specific competencies required

INDICATIONS

Indications for Placental Histopathology (Pathognomics)

- Severe fetal growth restriction (<3rd centile)
- Fetal growth restriction / pre-eclampsia requiring delivery prior to 34 weeks
- Still birth
- Unexpected admission to NICU for > 4hrs
- Late miscarriage (14 to 24 weeks gestation)
- Preterm delivery (< 34 weeks gestation)
- Morbidly adherent placenta
- Abnormal placental/umbilical cord or membranes anatomy on macroscopic examination

The only placentae sent to ASPH are those for suspected chorioamnionitis at term whose baby's are NOT admitted to NNU or babies admitted to NNU for <24 hours. This group of women will not routinely have clinical follow-up arranged.

Clinical Postnatal FU

This clinical follow-up is in addition to psychological support and debrief from the Birth Reflections service, should that be indicated.

Who

- All women who have placental histology sent to Pathognomics (as above)
- All Divisional, SI, HSIB and PMRT cases (these will be referred by the Q&S team
- All unexpected term admissions to NNU for >4 hrs
- Other clinical indications:
    - MOH> 1500ml
    - ITU admission
    - Full dilation CS
    - CS with T / J incision
    - Shoulder dystocia requiring manoeuvres
    - Difficult deliveries – impacted head / fractured bones / head trauma
    - Uterine Rupture

- The above list is not exhaustive and referrals will be considered for other indications should it be felt that it would benefit an individual family. This clinical follow-up is complimentary to the Birth Reflections Service rather than to replace it.

- Women who are transfers to ASPH from another unit should be offered the choice of either FU at ASPH or with the referring Unit, unless there is a a formal investigation report to be shared with the family such as a PMRT report in which case local FU at ASPH should be suggested. This can be a virtual consultation should the family prefer this.

- Default allocation is CoW unless significant care provided by one team in AN period (High Risk Obstetricians for FGR or PET requiring delivery prior to 34 weeks; Consultant Lead for Preterm Birth for care within the Preterm Birth clinic – this necessitates a consultant to consultant discussion and agreement to take over care). This does not refer to a single review on LW at time of delivery unless that individual choses to provide follow-up for continuity.

- Consultant of the Week (CoW) should therefore maintain clear oversight and input care proactively within their 'CoW' week as they will provide the PN care to these families too – this will include preterm births whose baby subsequently passes away days or weeks later.

Role of Allocated Clinical Consultant

- PMRT and Divisional Grade 3 - Provide clinical follow up with family and share report with them, either at initial review appointment or once report completed, dependent on timings. This will not be the PMRT report writer.
- SIRI / HSIB cases will need clinical FU as above but will also need the offer of a Trust meeting (+/- HSIB) for discussion of the report. This should be separate to the Clinical Lead and will be coordinated by the Quality and Safety Team.
- On occasions, a joint perinatal follow-up with the NNU team is most appropriate

PROCESS

How – PLACENTAE

- All placentae are to be stored within the fridge on Labour for 24hr post delivery and final decision for placental histology to be made at daily Safety Huddle and documented within the Bleep Log.

How – CLINICAL FOLLOW-UP

- The referral is made on BadgerNet for Postnatal Obstetrics Follow-Up referral by the MW caring for woman at time of delivery and registering the Birth on BadgerNet.
- As a safety net check, the midwife who is discharging the woman from either Joan Booker or Labour Ward, should check the referral has been made.
- eceived by 'Perinatal' administrator who coordinates clinical FU for all women
- Fortnightly meeting between Perinatal secretary. Bereavement Lead Obstetrician, Fetal Medicine Lead Obstetrician and Q&S team to ensure Perinatal Secretary has clear oversight of FU arrangements for ongoing cases
- Benefits
    - single point of contact for families and staff
    - able to liaise with Perinatal Governance admin to coordinate FU

Timing

- Offer appointment within 10 weeks – if a Post Mortem is requested, there is a likely longer time interval to receiving this and therefore may offer initial Clinical FU with offer of 2nd appointment once PM available?

Storage of Results

- All Postmortem, Genetics and Pathognomics results need to be uploaded onto BadgerNet by the Perinatal Administrator

RESPONSIBILITES

All clinical staff are responsible for complying with this policy.

AUDIT

An audit of all women having placental histology sent to ensure clinical follow-up has been provided.