The Shrewsbury and Telford Hospital NHS Trust

The Role of the Midwife Sonographer in Assisting with Feticide

(Maternity USS Department)

Version 3

Lead Person(s)	:	Dr Mohajer, Mr Gornall, Dr Hodgett, Fetal Medicine Consultants
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Written by	:	Alison Readman
Consultation	:	Dr Mohajer, Mr Gornall, Dr Hodgett, Maternity Ultrasound Department, Pharmacy Department
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1	27th May 2014	New	MGG	May 2017
2	24th October 2017	Full version review	MGG Maternity Governance	October 2022
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1.0 Introduction

1.1 Late termination of pregnancy can be an extremely traumatic event, not only for parents, but also for clinical staff. There are serious clinical, ethical and legal issues, and the case should be managed in accordance with the Royal College of Obstetricians and Gynaecologists recommendations (RCOG, 2014).

1.2 When undertaking termination of pregnancy, the intention is that the fetus should not survive, and the process should achieve this. Death may occur before delivery, either by the procedure undertaken by the obstetrician (feticide), or as a consequence of a compromised fetus being unable to tolerate induced labour (RCOG, 2010).

1.3 The incidence of live birth increases after 22 weeks gestation, therefore the current recommendation is for feticide for terminations after 21+ 6 weeks gestation (RCOG, 2023, 2014).

2.0 Aims

2.1 For the midwife sonographer to provide physical, emotional and psychological support to the woman/parents undergoing feticide.

2.2 To ensure that the parents are fully informed throughout the procedure.

3.0 Objectives

3.1 To provide clear, and evidence based guidance for midwife sonographers when assisting the Fetal Medicine Specialist (FMS) with a feticide procedure.

3.2 This guideline is intended to be used in conjunction with the trust guideline on fetal loss.

4.0 Definitions/abbreviations

4.1 **Feticide** *(*for the purposes of medical termination of pregnancy) is the intracardiac injection of potassium chloride solution (KCL) into the fetus, to ensure fetal asystole (RCOG, 2010).

4.2 **FMS** Fetal Medicine Specialist.

4.3 **MIS** Maternity Information System-local maternity electronic records; Viewpoint for ultrasound reports, Badgernotes (BN) for woman's notes.

5.0 Process

5.1 Preparation prior to Feticide Procedure

5.1.1 It is essential to have an agreed multidisciplinary management plan prior to late termination of pregnancy (RCOG, 2010), which should include the FMS, and as necessary, Neonatologist, Geneticist, Midwife Sonographer, Bereavement Specialist Midwife and any other appropriate professional.

5.1.2 Following diagnosis of the fetal abnormality, the parents will have consultations with the FMS, and other appropriate clinicians (neonatologist, geneticist, and cardiologist) regarding the prognosis and treatment options for the condition, and choices for the management of the pregnancy. The parents will be given the time they need to make a decision.

5.1.3 Once the decision to terminate the pregnancy has been reached, the method and process, including feticide, will be discussed in detail, and an agreed appointment arranged for this procedure.

5.1.4 The HSA1 agreement to termination of pregnancy form will be completed, in accordance with The Abortion Act (1967), by the FMS and countersigned by another FMS or Obstetrician. The Bereavement Specialist midwife/midwife sonographer will ensure that this form and the fetal loss pack and Feticide checklist are kept together. All documentation including HSA1 form and consent to feticide procedure will be scanned to the woman's BN. The feticide checklist will be scanned to BN once completed and the feticide procedure completed.

5.1.5 The signed consent to feticide procedure and the signed HSA1 form are retained in woman's hospital notes (in the maternity division).

5.1.6 The KCL (15% potassium chloride solution, 2mmol potassium per ml) will be prescribed by the FMS on a hospital prescription form. This will be obtained from pharmacy using the controlled drug order book, following notification by the midwife sonographer.

5.1.7If the woman has a Rhesus negative blood group, Anti D immunoglobulin will be ordered as per the 'Maternity Guideline Anti D for Rh D negative women and Standard Operation Procedure for requesting Anti D'

5.1.8 The KCL will be kept in the possession of the midwife sonographer until use. It can be ordered in advance, and then collected from pharmacy immediately prior to the procedure.

5.1.9 The consent to treatment form will be completed and signed by the woman and FMS, prior to the feticide procedure. The parents will have further opportunity to discuss any concerns at this time, and will have opportunity to meet with the bereavement midwife (if available) prior to, or following, the feticide procedure.

5.2 The Feticide Procedure

5.2.1 The procedure will be performed by the FMS under ultrasound guidance in accordance with the maternity guidelines on trans-abdominal ultrasound and amniocentesis. This procedure will be performed on Delivery Suite.

5.2.2 The midwife sonographer will assist the FMS in setting up for the procedure and in checking the KCL prior to administration.

5.2.3 The midwife sonographer will provide physical, emotional and psychological support to the woman/ parents during the procedure.

5.2.4 The feticide procedure is completed once fetal asystole has been observed for approximately 2 minutes.

5.2.5 The woman/parents will be informed that the procedure is complete, and condolences offered.

5.3 Care Following the Feticide Procedure

5.3.1 The midwife sonographer/Bereavement Specialist Midwife will escort the woman/parents to a private room when they feel ready, and will offer privacy/support and refreshments as required.

5.3.2 If the woman has a Rhesus negative blood group, anti-D immunoglobulin will be given in accordance with the 'Maternity Guideline Anti D for Rh D negative women and Standard Operation Procedure for requesting Anti D'.

5.3.3 The relevant Ultrasound department checklist for TOP (bereavement specialist midwife available or not available) will be initiated and completed by the midwife sonographer.

5.3.4 If the Bereavement Specialist midwife is away, the midwife sonographer will ensure that the family room is booked for the woman's return in 2 days time, and that the ward is aware of her planned admission.

5.3.5 The midwife sonographer will perform a follow up ultrasound scan 30- 60 minutes following the feticide to confirm fetal asystole if the FMS not available at this time. Any deviation from expected will be immediately referred back to the FMS.

5.3.6 The midwife sonographer will administer the Mifepristone 200mg to the woman, as prescribed if the Bereavement Midwife not available.

5.3.7 The Maternity Information System (MIS) workflow, and the ultrasound TOP checklist, will be completed and the documentation scanned to the the woman's BN .

5.3.8 If the Bereavement Midwife not available to take over care, the midwife sonographer will ensure that the woman/parents have the relevant contact telephone numbers for the ward to which they are to be admitted, the labour ward, ultrasound department and bereavement midwife. She will ensure that they also know their admission date and time for the remainder of the medical TOP procedure, and are aware of the process of this procedure.

6.0 Training

6.1 All midwife sonographers will hold an accredited ultrasound qualification as specified by FASP (2024).

6.2 All midwife sonographers will attend relevant continuous professional development training as required by the NMC and Fetal Anomaly Screening Programme (FASP).

6.3 All midwife sonographers will ensure that their frequency of practice affords the maintenance of skill levels.

7.0 Monitoring/audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out using the auditable standards and the results will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

8.0 References

Fetal anomaly screening programme handbook - GOV.UK (www.gov.uk) latest update 19/02/2024

Nursing and Midwifery Council (2015). The Code. Professional standards of practice and behaviour for nurses and midwives.

Royal College of Obstetricians and Gynaecologists.(May, 2010).Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales.

Royal College of Obstetricians and Gynaecologists. (2014). RCOG Report: Further Issues relating to Late Abortion, Fetal Viability and Registration of Births and Deaths

Royal College of Obstetricians and Gynaecologists. December 2023. Position statement following Chief Coroner's Guidance no. 45, 'Stillbirth and Live Birth Following Termination of Pregnancy'. Advice for clinicians following abortion care at later gestation.

Appendix- Equipment required for feticide

Documentation Required

- White HSA1 agreement to termination of pregnancy form, signed by FMS and countersigned by second obstetrician
- Completed hospital prescription sheet
- Consent form signed by patient and countersigned by FMS
- TOP checklist
- Appropriate fetal loss pack from bereavement midwife.

Equipment for procedure

- VE/ amniocentesis pack
- Hydrex Pink (chlorhexidine 0.5%) solution
- 10ml syringe with green needle (for KCL)
- 5ml syringe with orange and green needles (for Lignocaine injection)
- Heparinised syringe **OR** heparin and 2.5ml syringe
- Yellow 20GA needle

Drugs for procedure

- Potassium chloride solution for injection (15%/ 2mmol per ml)
- Lignocaine hydrochloride solution for injection 2% (for local anaesthetic)
- Mifepristone 200mg tablet (for administration after procedure)