

Perinatal care at the threshold of viability

Clinical Guideline Presentation v1.0



45 minutes

Towards your CPD Hours

References:

The Queensland Clinical Guideline *Perinatal care at the threshold of viability* is the primary reference for this package.

Recommended citation:

Queensland Clinical Guidelines. *Perinatal care at the threshold of viability* Clinical guideline education presentation I14.56-V1-R19 Queensland Health. 2014.

Disclaimer:

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

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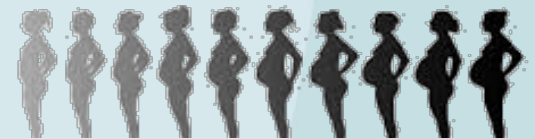


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Threshold of viability

- There is national and international debate on where the threshold of viability lies
- Queensland Clinical Guideline: 23+0 weeks – 25+6 weeks
- Decisions need to take into account other prognostic factors as well as gestation (e.g. sex, birth weight, plurality, congenital anomalies, antenatal pathology)



Family centred care



- **Respect and dignity**
 - Listen to and honour family choices
- **Information and sharing**
 - Share complete and unbiased information
- **Participation**
 - Support parental involvement
- **Collaboration**
 - Involvement on an institutional wide basis

Ethical principles



Principle	Meaning
Non-maleficence	<ul style="list-style-type: none">• Do no harm / minimise harm
Beneficence	<ul style="list-style-type: none">• Act for the benefit of others
Autonomy	<ul style="list-style-type: none">• Make own decisions and life choices• Premature babies must rely on others
Justice	<ul style="list-style-type: none">• Actions that are fair to those involved

Legal considerations



- ‘*Best interests of the baby*’ is the legal principle underpinning all decisions relating to resuscitation
- No legal definition of viability or when resuscitation should or should not occur
- Australian case law affirms withdrawal of life sustaining treatment can be in the best interest of the baby, and parents can consent to withdrawal of treatment

Best interests

- Includes an assessment of:
 - Pain and suffering
 - Inevitability of death
 - Quality of life
 - Interests of family and other parties
- Healthcare team not obliged to provide or withhold interventions that are not in the best interests of the baby

Withdrawing or withholding care

- No ethical or legal distinction between withholding and withdrawal of life sustaining interventions when decisions are motivated by an assessment of the best interests of the baby
- Signals a shift in focus to palliative care

Decision making

- Parent(s) and family central to approach
- Collaborative
- Multidisciplinary
- Involve all relevant parties
- Led by an experienced practitioner



Managing conflict



- May occur within healthcare team and/or between healthcare team and family
- Attempt to resolve conflict before birth
- Identify key contacts to ensure consistent approach
- Consider conflict resolution or mediation, independent medical consultant, transfer of care, clinical ethics committee, or legal involvement (last resort)



Documentation

- Commence a plan of care at the earliest opportunity
- Involve the family in care planning
- Document all discussions and decisions clearly and unambiguously
- Review and update regularly as the clinical situation evolves

Sharing information

- Prepare for discussions
 - Review history
 - Assess prognostic certainty
 - Ascertain parental knowledge
- Incorporate cultural considerations
- Provide opportunity for detailed discussion and questions
- Offer written information

Counselling

- Main purpose is to inform the family and assist with decision making
- Compassionate but realistic assessment
- Acknowledge prognostic uncertainty
- Involve others (e.g. specialities)
- Discuss expectations for care including palliative care
- Include psychological supports

Factors influencing viability

- Gestational age
- Improved outcome if:
 - Female
 - Singleton
 - Appropriate higher birth weight for gestational age
- Worsened outcome:
 - Significant fetal anomaly
 - Severe antenatal pathology



Longer term outlook

- Significant morbidities occur in babies born at the threshold of viability
 - Cerebral palsy
 - Intellectual disability
 - Cognitive impairment
 - Sensory deficits
 - Chronic health problems
 - Restrictions in activities of daily living



Quality of life



- Considers more than ‘what are the chances of survival’
- Impairment is not incompatible with a life of quality
- Exists on a continuum and people vary where they would choose death or no resuscitation

In-utero transfer

- Best survival rates: Inborn at neonatal units that manage high volumes of very low birth weight babies
- Coordinate transfer via QCC
- Aim for in-utero transfer unless:
 - Palliative care planned
 - Birth imminent at < 23 weeks



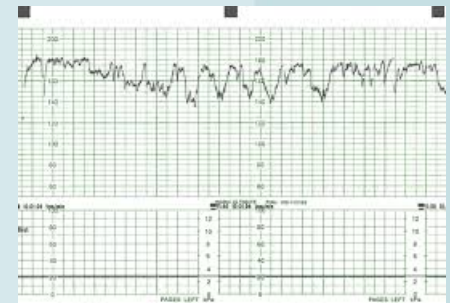
Antenatal corticosteroids

- Recommend corticosteroids where treatment is planned or may be a possibility
- Administration does not oblige or equate to a final decision for active treatment
- Consider additional dose if more than 7 days since initial dose



Cardiotocograph (CTG)

- Take into account fetal physiology at less than 28 weeks gestation
- CTG not recommended at less than 24 weeks
- May have limited usefulness between 24 and 28 weeks gestation depending on circumstances



Magnesium Sulfate

- Reduces risk of cerebral palsy
- Recommend between 23+0 and 30+0 weeks gestation where active treatment is planned or a possibility and birth is imminent
 - Commence as close to 4 hours prior to birth as possible
- Repeat dose may be considered if birth does not occur

Caesarean section

- Evidence is lacking on optimal mode of birth
- Not recommended for fetal indications alone at less than 24 weeks
- Not usually recommended between 24+0 and 24+6 weeks for fetal indications alone
- May be recommended from 25+0 weeks depending on individual circumstances

Care at birth

- If resuscitation an option:
 - Regard as an emergency
 - Experienced practitioner present
- If gestation uncertain - initiate interventions until clinical course clearer
- Discuss baby's condition with family as soon as possible
- Provide palliative care if resus not planned



Resuscitation

Also consider other prognostic factors when making decisions

Gestation	Life sustaining interventions
< 23 weeks	<i>Not recommended</i> <ul style="list-style-type: none">• Palliative care if live birth
23+0 - 23+6	<i>Not usually recommended</i> <ul style="list-style-type: none">• Support an informed decision by the family for intervention
24+0 - 24+6	<i>Usually recommended</i> <ul style="list-style-type: none">• Support an informed decision by the family for palliative care
25+0 - 25+6	<i>Recommended</i> <ul style="list-style-type: none">• Consider individual circumstances if an informed decision by the family is for palliative care

Palliative care planning

- Assess the baby's clinical condition
- Develop a care plan with the family
 - Review and update plan frequently
- Involve palliative care specialists
- Document all decisions clearly and unambiguously



Palliative care



- Involve family in newborn care
- Gastric feeding not usually recommended
- Cease unnecessary interventions, monitoring and medications
- Assess and administer pain relief as required
- Avoid invasive procedures
- Incorporate non-pharmacological interventions

Bereavement support

- Tailor support to family needs
- Maintain a family centred approach
- Involve social worker/psychological supports
- Facilitate maternity care as required
- Facilitate memory creation



Follow-up after bereavement

- Provide information about burial and cremation
- Offer appointment to discuss events
- Provide contact information for psychological supports
- Consider needs for subsequent pregnancies
- Inform community carers (e.g. GP)