**Safer baby**

Your toolkit for improvement work to reduce stillbirth

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**Safer baby toolkit**

## Who is this toolkit for?

This resource is for maternity services who are planning improvement work to reduce the rate of stillbirths in the third trimester of pregnancy. This toolkit is based on the [The Safer Baby Bundle](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/) which was developed by the Stillbirth Centre of Clinical Excellence (CRE) which promotes the use of 5 evidence-based elements to address key areas where improved practice can reduce the number of stillborn babies.

## What is the toolkit?

This toolkit is based on quality improvement and improvement theory developed for the [Safer baby collaborative](https://www.safercare.vic.gov.au/improvement/projects/mbc/safer-baby) < https://www.safercare.vic.gov.au/improvement/projects/mbc/safer-baby>

The toolkit includes:

* brief background information on the Safer baby collaborative
* your step-by-step guide to getting started with reducing stillbirth
* the Safer baby collaborative driver diagram
* Safer baby change ideas, with links to resources to support your work

## Background

### What is the Safer baby collaborative?

We know that in many cases stillbirth is preventable, and research shows that 20-30% of late gestation stillbirths could be avoided with better care (CCOPMM, 2020). Most recent data from 2020 shows that Victoria’s stillbirth rate is 6.4 per 1,000 births after 20 weeks, with 178 stillbirths after 28 weeks (Stillbirth CRE).

From 2019 until 2021, SCV and the Institute for Healthcare Improvement (IHI) partnered with 19 health services to deliver the Victorian [Safer baby collaborative](https://www.safercare.vic.gov.au/improvement/projects/mbc/safer-baby) which aimed at reducing preventable stillbirths in participating services through the introduction of an evidence-based bundle of care.

This bundle of care aligns with work undertaken in the United Kingdom as part of the Saving Babies Lives Care Bundle and with the [Safer Baby Bundle](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/) work as developed by the Stillbirth CRE.

Partnering with consumers and encouraging participating and collaboration in care can help improve the safety and quality of care. SBC used the [‘Partnering in healthcare’ framework](https://www.safercare.vic.gov.au/sites/default/files/2019-02/Partnering%20in%20healthcare%20framework%202019_WEB.pdf) to elevate the consumer voice by engaging broadly with consumers in leadership roles within SCV and across the participating teams.

### What did the Safer baby collaborative set out to achieve in?

### The aim of the Safer baby collaborative was to reduce the rate of stillbirths in the third trimester by 30% in participating services.

### The collaborative targeted stillbirth at 28 weeks or more, a period of gestation in which more cases are considered to be avoidable and excludes terminations and babies with lethal congenital or chromosomal abnormalities

### What did we accomplish?

* partnered with women during their care, to support identification of risk factors and shared decision making
* used improvement science as a framework for learning and change, including collecting data to understand our progress against a family of measures
* worked towards consistent, reliable practice in the key areas of clinical care:
* supporting women to stop smoking during pregnancy
* identification and management of fetal growth restriction
* sharing information about and responding to decreased fetal movements
* sharing information about maternal sleep position

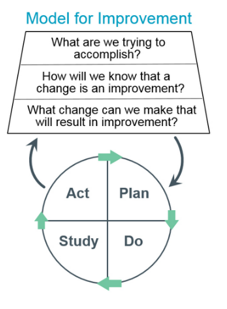


Figure 1: Model for improvement

* shared decision-making around timing of birth.

## Using the model for improvement

### Your step-by-step guide

This guide brings together foundational quality improvement methods, the [Model for Improvement](https://www.safercare.vic.gov.au/improvement/step-by-step-guide-to-using-the-model-for-improvement) (see Figure 1), and information from the Safer baby collaborative. The Model for Improvement helps us deliver improved outcomes and support improvement in healthcare.

The Model for Improvement asks you to respond to three questions as you plan and undertake improvement work and it includes the plan-do-study-act (PDSA) cycle as the engine for developing, testing and implementing change in your system. Thoughtful, collaborative consideration of the three questions enables deep understanding of the problem or opportunity for improvement, identification of high-quality change ideas, and construction of an effective measurement strategy to capture learning and track progress.

1. Build your team

#### Improvement teams

Effective improvement in our complex healthcare system requires a team approach to share the work and to provide diverse knowledge and experience. Ideally, your team will include:

* a team leader who will be responsible for coordinating and driving the work
* at least one consumer with lived experience of your health service
* someone with quality improvement knowledge and experience with training in improvement science
* multidisciplinary representation with strong clinical leadership including medical (obstetricians, obstetric registrars, GPs) and midwifery staff
* a senior sponsor.

#### Senior sponsor

Support from your health service executive leadership is critical to enabling protected time to dedicate to the improvement work, access to resources, removal of barriers to progress and organisational commitment. Your senior sponsor is essential in championing your work within your health service and helping you sustain will and engagement throughout the work.

#### Partnering with consumers

Involving consumers in improving systems of care and the care they receive can strengthen outcomes. When patients, caregivers and families contribute to the design and development of strategies for improvement in care provision, local solutions to local problems are created based on the needs of the recipients of that care. If you are unsure where to start with consumer recruitment, reach out to the consumer liaison service in your hospital and/or the SCV Partnering & Consumer team.

#### Applying an equity lens

When forming your team, consider how you will attract diverse perspectives and experiences. For example, the view of Aboriginal and Torres Strait Islander people, people who are culturally and linguistically diverse, women and LGBTQI+, and others who may be experiencing disadvantage. Including a diverse range of people can ensure solutions work across the population.

Helpful tools:

* [SCV Partnering in healthcare framework](http://www.safercare.vic.gov.au/support-training/partnering-with-consumers/pih) <www.safercare.vic.gov.au/support-training/partnering-with-consumers/pih>
* [Cultural responsiveness framework – Guidelines for Victorian health services](http://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services) <www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services>
* [Designing for Diversity](http://www.health.vic.gov.au/populations/designing-for-diversity) <www.health.vic.gov.au/populations/designing-for-diversity>
* [Institute for Healthcare Improvement (IHI) Achieving health equity](https://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx) <https://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

1. Explore your opportunity for improvement

#### What does the data tell you?

At this stage of your work, data is key to understanding how many stillbirths happen at your service, and the consistency and reliability of care in key areas of clinical practice connected to stillbirth.

Measures set out in the table below were used by participating services during the Safer baby collaborative to know whether the changes they were making and testing were leading to improvement. You may wish to use these to understand your system’s current performance, collecting data across all measures to form a baseline before beginning to test changes. You could also undertake a ‘deep dive’, reviewing recent cases of stillbirth to explore whether there are gaps in the key areas of care.

Remember the equity lens: the segmentation of data by social groupings can help target improvement efforts to those who may be most disadvantaged.

Table 1. Improvement Program Measures: Adapted from Safer Babies Collaborative measures

|  |  |
| --- | --- |
| **Required measures** | |
| Outcome Measures | * Percentage of stillbirths at 28 weeks or more gestation excluding congenital anomalies |
| Process Measures | **Bundle element 1: Supporting women to stop cigarette smoking in pregnancy**   * Percentage of women who continue to smoke during pregnancy * Percentage of women identified as smoking, who received ‘Ask, Advise, Help’ intervention   **Bundle element 2: Improving detection and management of fetal growth restriction**   * Percentage of women who have a symphyseal fundal height measurement taken and plotted on growth chart at each antenatal visit from 24 weeks gestation * Percentage of women who were screened for fetal growth restriction at first antenatal visit   **Bundle element 3: Raising awareness and improving care for women with decreased fetal movements**   * Percentage of women provided with decreased fetal movement (DFM) information and education from 24 to 28 weeks gestation * Percentage of women at 28 weeks’ gestation or more who have a cardiotocography (CTG) commenced within two hours of arrival at health service following a report of DFM   **Bundle element 4: Improving awareness of maternal safe sleeping position**   * Percentage of women who are provided with maternal sleep position education & brochure from 28 to 34 weeks gestation   **Bundle element 5: Improving decision-making around timing of birth for women with risk factors at term**   * Percentage of women who report being involved as much as they wanted to with decision-making around timing of birth |
| Balance Measures | * Percentage of women who birth, via induction or caesarean section before 39.0 weeks gestation * Percentage of babies with a birthweight >25th centile actively delivered for suspected FGR between 37.0-39.0 weeks gestation |
| **Optional measures** | |
| Outcome Measures | * Percentage of compliance with all five elements of clinical care bundle |
| Process Measures | **Bundle element 2: Improving detection and management of fetal growth restriction**   * Percentage of women who were screened for fetal growth restriction at every antenatal appointment from 24 weeks gestation * Percentage of women (at any gestation) identified as at risk of FGR (level 2 or 3) whose care is escalated as per the FGR care pathway   **Bundle element 3: Raising awareness and improving care for women with decreased fetal movements**   * Percentage of women at 24 weeks’ gestation or more who present within 12 hours of reporting DFM   **Bundle element 5: Improving decision-making around timing of birth for women with risk factors at term**   * Percentage of women who report receiving information regarding stillbirth risk factors after 34 weeks gestation during timing of birth discussion |

#### What do you know about the processes driving current practice?

Understanding your health service involves knowing the steps in the woman’s journey through pregnancy, labour and birth, and the factors affecting her experiences and outcomes. Detailed understanding of this will help you and the team identify where there are inconsistencies, gaps, duplications, or delays.

Helpful activities:

* Deep Dive Case Studies
* Process mapping
* Affinity mapping
* Cause and effect (fishbone/Ishikawa) analysis

* [IHI QI Essentials toolkit: Maternal health](http://www.ihi.org/Engage/Initiatives/Better-Maternal-Outcomes-Rapid-Improvement-Network/Documents/IHI_QIEssentialsToolkit_MaternalHealth.pdf) <www.ihi.org/Engage/Initiatives/Better-Maternal-Outcomes-Rapid-Improvement-Network/Documents/IHI\_QIEssentialsToolkit\_MaternalHealth.pdf>

#### What are the people telling you?

Change is an integral part of improvement work, but this is not always embraced by individuals or teams. It can be challenging to build and maintain momentum in the face of the resistance that change can provoke.

What do you know about the culture, communication and teamwork in your context? Do you know who might be your champions for change?

Helpful tools:

* [IHI Psychology of change framework](https://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx) <www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx>

1. What will you try to accomplish?

What are the specific, measurable, achievable, relevant, and timely (SMART) goals for your team? How much do you want to improve by? How can you set a goal that will energise and motivate, without seeming too far out of reach or too easy?

What is your timeframe? Is it a realistic match for how much you want to improve by and the complexity of your system? Is there a particular part of your service you want to focus on?

1. What will you focus on?

In quality improvement work, the ideas and potential solutions we want to test in our system are referred to as change ideas. A change idea is an actionable, specific idea for changing a process. It can come from research, best practices, or from other organisations that have recognised a problem and have demonstrated improvement on a specific issue.

Change ideas can be tested to determine whether they will result in improvement and are often revised because of these tests. In the Safer baby collaborative driver diagram you will see change ideas down the right-hand side. The diagram is followed by a series of tables linking the ideas to resources teams have used and developed when testing and implementing these changes. Change ideas in the collaborative came from research, work undertaken in other jurisdictions, and maternity services participating in the collaborative.

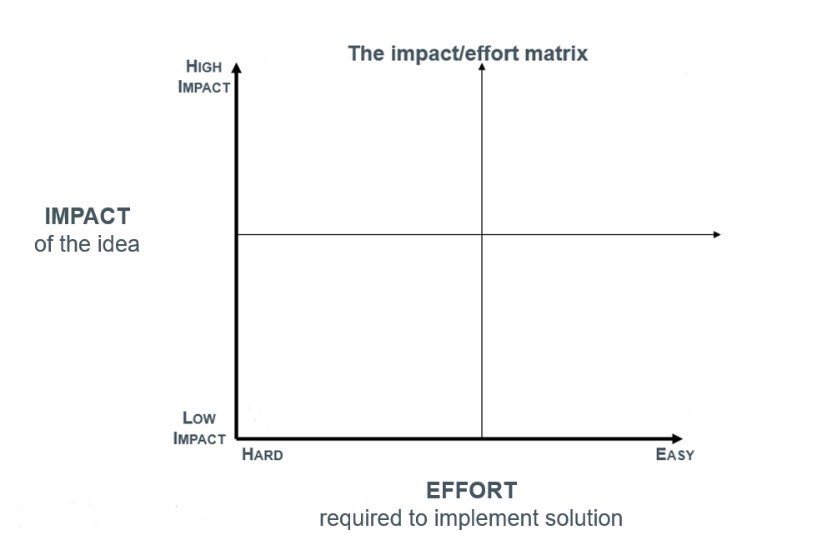


Figure 2: Impact/effort matrix

Consider the change ideas included in this toolkit as a menu of options from which you can choose the most relevant or highest priority area to address in your health service. Your data, understanding of current practice, clinicians and consumers voice and organisational priorities will guide how you prioritise ideas. Some teams may start with one driver. Others may choose to start by tackling one idea across all three drivers. Many teams find it helpful to start with the ‘low hanging fruit’, to build belief in the work.

Helpful tools:

* [IHI Changes for improvement](http://www.ihi.org/resources/Pages/Changes/default.aspx) <www.ihi.org/resources/Pages/Changes/default.aspx>
* [Prioritising change ideas: impact/effort matrix](https://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Priority-Matrix-An-Overlooked-Gardening-Tool.aspx) (Figure 2) <https://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Priority-Matrix-An-Overlooked-Gardening-Tool.aspx>

1. How will you know that change is an improvement?

Measurement is essential to help learn about the impact you are having as you test changes in a wide range of conditions, whether changes are leading to improvement and what the next steps could be. You and your team will collect and learn from data in real time, using annotated charts to understand your impact, adjust your hypotheses along the way, and see progress towards your aim.

#### A family of measures

A small [family of measures](https://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx#:~:text=Three%20Types%20of%20Measures,process%20measures%2C%20and%20balancing%20measures.) will help track your progress:

* one or two outcome measures aligned to your aim
* up to five process measures aligned to activities or practices logically connected to your aim
* one or two balancing measures to monitor potential indirect impacts in your system.

You may wish to use measures from the collaborative (Table 1) or develop measures to suit your context.

#### Collecting data: when and how much?

The focus of data collection for improvement is specificity and frequency: is your data directly connected to your project and are you collecting it frequently enough to learn and respond quickly?

Frequency of data collection may look like:

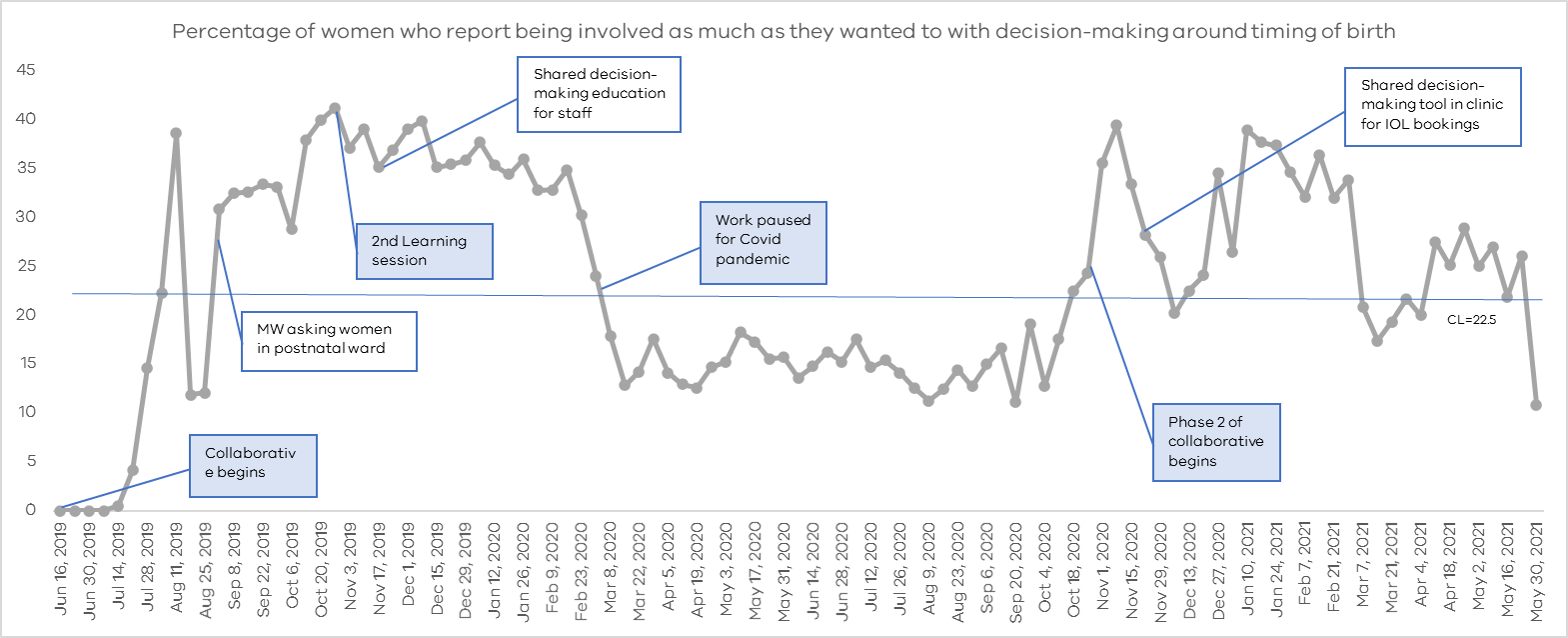
* outcome measures –monthly
* process measures – weekly
* balance measures – monthly.

You will need to collect just enough data to learn whether your changes are having an impact on your system. Too much and all your time will be taken up with data collection. Too little and you won’t learn effectively. A good place to start is to sample 10 patient records per week, noting that your data collection opportunities will vary depending on your service size.

#### Making sense of your data

Displaying your data on charts will help you understand the impact of your changes, assess progress, and communicate progress with stakeholders. A run chart is a line graph of data over time, demonstrating performance of a process and enabling you to determine between expected (common cause) and unexpected (special cause) variation. Annotating your run charts to show when tests of change happen will increase your understanding of how these changes are influencing practice.

Figure 3: Run chart example: Process measure



Helpful tools:

* [IHI measurement for improvement](http://www.ihi.org/resources/Pages/ImprovementStories/SuccessfulMeasurementForImprovement.aspx) <www.ihi.org/resources/Pages/ImprovementStories/SuccessfulMeasurementForImprovement.aspx>
* [Run chart rules](https://www.ihi.org/education/IHIOpenSchool/Courses/Documents/11_RunChartRulesReferenceSheet.pdf) <https://www.ihi.org/education/IHIOpenSchool/Courses/Documents/11\_RunChartRulesReferenceSheet.pd>

**Introducing changes into your system**

Testing change using PDSA enables teams to learn what works and what does not in their efforts to improve processes. Initially, cycles are carried out on a small scale to see if they result in improvement, e.g. one patient on one day. Teams then expand tests and gradually incorporate larger and larger samples until they are confident that changes will result in sustained improvement.

It is important to complete each of the four stages of a PDSA cycle:

* **Plan** – be clear about what you are trying to learn with this PDSA cycle, note the questions you have and make predictions about what will happen, and document details of the test (who, what, when, where and how)
* **Do** – carry out the plan, observe and measure (that is, collect data) what happens. Take notes of what went well and what didn’t
* **Study** – analyse and compare data, check your observations against your predictions, summarise learnings
* **Act** – decide on what will happen next: will you adapt the change and test again, adopt the change, or abandon it and try something different with your next PDSA cycle?

#### Communication

Throughout your improvement initiative, communication is critical for:

* supporting effective teamwork
* working productively with your team’s senior sponsor
* building and sustaining will through stories
* connecting with others on the same mission.

In this section, we suggest ideas and pose questions to address these needs.

#### Supporting effective teamwork

Your team will need to connect frequently. What modes of communication do you already use which could support frequent contact? What modes of communication are accessible for consumers or other non-clinical members of your team? These might include:

* email
* WhatsApp message group
* Microsoft Teams chat
* regular phone calls
* shared documents for asynchronous development
* a physical message board
* face-to-face or video-chat huddles
* regular face-to-face or virtual team meetings.

#### Working with your senior sponsor

To best support your work, remove barriers, and champion your cause, your team’s sponsor needs to be up-to-date with your improvement plans, successes and challenges. Keeping up to date can be achieved by:

* inviting your sponsor to team meetings regularly
* inviting your sponsor to all key project events
* sharing improvement stories and data that your sponsor can share more widely
* reaching out when you encounter barriers to your work progressing.

#### Building and sustaining engagement through stories

Narrative is highly effective at engaging the head and the heart. Great stories teach us not only how we ought to act but motivate us to act. Stories can be collected and shared from both a patient and staff/health service perspective. Consumer stories in particular are powerful tools to help us learn, improve and build engagement across health service teams. Public narrative is composed of three elements: a story of self, a story of us, and a story of now. A story of self communicates *who I am* – my values, my experience, why I do what I do. A story of us communicates *who we are* – our shared values, our shared experience, and why we do what we do. And a story of now *transforms the present into a moment of challenge, hope and choice*.

We strongly recommend taking the time to capture your stories as you go. This could be by:

* taking photos
* recording observations
* creating brief video interviews or audio recordings
* writing blog posts
* sharing social media posts
* presenting at conferences and forums.

#### Connecting with others on the same mission

Having the opportunity to connect with other people undertaking improvement work, to learn from their successes and failures, and to share your own so others can benefit from your experience, is an important factor in sustaining motivation, gathering ideas and strengthening your improvement approach. This could be within your service, your community, across the state or even nationally. Consider:

* asking your manager what other improvement work is happening at your service
* reaching out to your local Primary Health Network (PHN)
* reaching out to your professional college
* joining a community of practice
* starting a community of practice
* connecting with the team at SCV: [maternityandnewbornlhn@safercare.vic.gov.au](mailto:maternityandnewbornlhn@safercare.vic.gov.au)

## Safer babies - Driver diagram

This driver diagram was developed in partnership with the Collaborative Faculty which included clinicians and consumers. It has been updated since the completion of the collaborative in line with stakeholder feedback.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AIM**  **What we want to achieve** |  | **PRIMARY DRIVERS**  **Parts of the system we will influence** |  | **SECONDARY DRIVERS**  **Where and when we will influence the system** |  | **CHANGE IDEAS**  **How we will influence the system** |
|  |  |  |  |  |  |  |
| By x we intend to reduce the stillbirth\* rate by x in participating health services.    *\*Stillbirth is defined as birth without signs of life at 28 weeks or more, excluding terminations and lethal congenital or chromosomal abnormalities.* |  | Partnering with women |  | At booking |  | * Discuss expected length of pregnancy with all women * Include the consumer-designed poster and sticker, outlining 5 bundle elements, in all booking packs * Include information about stillbirth risk factors (smoking, fetal growth restriction (FGR), decreased fetal movements (DFM), maternal sleep position) |
|  |  |  |  |  |
|  |  | At pregnancy care appointments |  | * Discuss stillbirth risk factors (smoking, FGR, DFM, maternal sleep position) at every visit * Share links to the Stillbirth CRE Safer Baby Bundle consumer site   ***Bundle element 3: Management of decreased fetal movements***   * Share the ‘Movements matter’ resources with every woman   ***Bundle element 4: Promoting optimal maternal sleep position***   * Share the ‘Sleep on side’ video and resources with every woman * Ask every woman about sleep position, during pregnancy care appointments in the third trimester |
|  |  |  |  |  |
|  |  | When planning for timing of birth |  | ***Bundle element 5: Shared decision-making around timing of birth***   * Use shared decision-making tools to guide and document discussions * Share the ‘Every week counts’ resource with all women * Screen for stillbirth risk at term |
|  |  |  |
|  |  |  |
|  |  |  |  |  |  |
|  | Application of the bundle elements |  | Routine professional development |  | * Incorporate education and training on the five clinical interventions, shared-decision making and providing informed consent * Create training videos for the five clinical interventions * Introduce daily SBC huddles in antenatal clinic, to gather feedback and share information * Incorporate teach-back skills * Identify opportunities for in-the-moment teaching, reflection and clinical reasoning development |
|  |  |  |  |  |
|  |  | Every episode of care |  | ***Bundle element 1: Promoting smoking cessation***   * Screen for smoking behaviours using the Ask, Advise, Help brief advice intervention * Refer to Quit services * Include partners and other family members in screening and referral * Share information with GPs |
|  |  |  |  |
|  |  |  | ***Bundle element 2: Detection and management of fetal growth restriction (FGR)***   * Screen all women for their risk of FGR * Use a consistent technique for measuring symphyseal fundal height (SFH) * Plot symphyseal fundal height (SFH) and estimated fetal weight (EFW) on growth charts |
|  |  |  |  |  |
|  |  | When reported |  | ***Bundle element 3: Management of decreased fetal movements***   * Assess all women who report DFM as soon as possible |
|  |  |  |
|  |  |  |
|  |  |  |

#### Primary driver: Partnering with women

Partnering with women and their support people is essential in achieving success. This part of the change package focuses on approaches to partnering and opportunities for sharing critical information at different stages: during pregnancy care, and during and after birth.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Secondary driver | Change ideas | Explanation | Resources/References | Your team’s ideas |
| At booking | Discuss expected length of pregnancy with all women |  | [Albury/Wodonga Pregnancy Journey Map](https://gatewayhealth.org.au/wp-content/uploads/2021/07/Wodonga-Pregnancy-Journey-Map-2019-FINAL.pdf) |  |
| Include the consumer-designed poster and sticker, outlining 5 bundle elements, in all booking packs |  | [Smoking Cessation - consumer information](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/smoking-cessation/) – Stillbirth CRE  [Fetal Growth Restriction – consumer information](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/fetal-growth-restriction/)  [Decreased Fetal Movement – consumer information](https://stillbirthcre.org.au/parents/safer-baby/movements-matter/)  [Side Sleeping Resources | The Centre of Research Excellence in Stillbirth (stillbirthcre.org.au)](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/side-sleeping-resources/)  [SB\_TOB\_brochure\_A5.pdf (stillbirthcre.org.au)](https://stillbirthcre.org.au/wp-content/uploads/2022/09/SB_TOB_brochure_A5.pdf)  [Translated resources](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/translated-resources/) – Stillbirth CRE |  |
| Include information about stillbirth risk factors (smoking, FGR, DFM, maternal sleep position) | Stillbirth risk factors should be discussed and assessed as early as possible in a woman’s pregnancy and throughout the antenatal period.  For a list of risk factors – see the Stillbirth Clinical Care Standard | [Safer Baby Bundle](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/) - Stillbirth CRE  [Still Birth Clinical Care Standard](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/stillbirth-clinical-care-standard-2022#:~:text=The%20Stillbirth%20Clinical%20Care%20Standard%20contains%2010%20quality,the%20quality%20of%20bereavement%20care%20following%20perinatal%20loss.) – ACSQHC |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Secondary driver | | Change ideas | Explanation | Resources/References | Your team’s ideas | |
| At pregnancy care appointments | | Discuss stillbirth risk factors (smoking, FGR, DFM, maternal sleep position) at every visit | As above | [Safer Baby Bundle](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/) - Stillbirth CRE  [Stillbirth Clinical Care Standard](https://www.safetyandquality.gov.au/standards/clinical-care-standards/stillbirth-clinical-care-standard) – ACSQHC |  | |
| Share links to the Stillbirth CRE Safer Baby Bundle consumer site | The Stillbirth CRE Safer Baby Bundle website has important resources for consumers. | [Safer Baby Bundle](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/) - Stillbirth CRE  [Translated resources](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/translated-resources/) – Stillbirth CRE |  | |
| **Bundle element 3: Management of decreased fetal movement**  Share the ‘Movements matter’ resources with every woman | Decreased fetal movement is a significant riskfactor for stillbirth and therefore needs to be discussed routinely with women to increase awareness.  During pregnancy, clinicians must support women to become familiar with their fetal movement and provide education, using teach back technique, on the importance of fetal movement. Additionally, this discussion should include advice on prompt care seeking if the women is perceiving any changes in movement patterns.  The ‘Movements Matter’ resource can support such discussions. | [Movements Matter](https://stillbirthcre.org.au/parents/safer-baby/movements-matter/) – Stillbirth CRE  [Translated resources](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/translated-resources/) – Stillbirth CRE  [Always Use Teach Back!](https://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx#:~:text=The%20Always%20Use%20Teach%20Back,at%20www.teachbacktraining.com.) - IHI  [Teach-back](http://teachback.org/research/) |  | |
| **Bundle element 4: Promoting optimal maternal sleep position**  Share the ‘Sleep on side’ video and resources with every woman | Side sleeping advice should be provided by week 28 of pregnancy.  Using teach back technique, clinicians should discuss and provide information on side sleeping throughout the antenatal period. | [Going to sleep on your side from 28 weeks – Stillbirth CRE](https://stillbirthcre.org.au/parents/safer-baby/going-to-sleep-on-your-side-from-28-weeks/)  [Translated resources](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/translated-resources/) – Stillbirth CRE  [Side sleeping resources](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/side-sleeping/) – Stillbirth CRE  [Mothers’ going-to-sleep position in late pregnancy](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element_4_Side_Sleeping_Position_Statement-1.pdf) – Position statement, Stillbirth CRE and PSANZ |  | |
| Ask every woman about sleep position, during pregnancy care appointments in the third trimester | As above |  |  | |
| Secondary driver | Change ideas | | Explanation | Resources/References | | Your team’s ideas |
| When planning for timing of birth | **Bundle element 5: Shared decision-making around timing of birth**  Use shared decision-making tools to guide and document discussions | | Shared decision-making is an important part of delivering women-centred care. It involves sharing of information, discussion and collaboration between a consumer and their healthcare provider and needs to be incorporated throughout the care continuum.  Information should be in a form that can be used and understood by patients and is appropriate to their health literacy, language and cultural needs.  Timing of birth should be discussed throughout the antenatal period and women should be provided with information that enables them to make informed decisions about timing of birth. These decisions should be made with collaboration between the woman and clinician and based on a clear understanding of their individual risks and reflective of their preferences and values. | [Improving decision-making about the timing of birth for women with risk factors for stillbirth.](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-5_Timing-of-Birth-Position-Statement-1.pdf) – Position statement, PSANZ and Stillbirth CRE  [Shared decision making](https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making) – ACSQHC  [Using plain language in health information](https://www.plainlanguage.gov/resources/content-types/healthcare/)  [Easy English](https://www.health.tas.gov.au/professionals/health-literacy/health-literacy-workplace-toolkit/written-communication/easy-english)  [The Power of Four Words: "What Matters to You?" | IHI - Institute for Healthcare Improvement](http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx)  [Delivering Great Care: Engaging Patients and Families as Partners | IHI - Institute for Healthcare Improvement](https://www.ihi.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx)  [Stillbirth Clinical Care Standard](https://www.safetyandquality.gov.au/standards/clinical-care-standards/stillbirth-clinical-care-standard) – ACSQHC | |  |
| Share the ‘Every week counts’ resource with all women | | All women should be provided with written and verbal explanations of the risks and benefits associated with timing of birth decisions.  Determining the optimal timing of birth involves balancing the short and long-term health benefits to the mother and her baby, with any risks specific to her pregnancy.  'Every Week Counts’ provides useful resources for women to support informed decision making. | [Every Week Counts website](https://everyweekcounts.com.au/healthcare-professionals/)  [Timing of Birth resources](https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/timing-of-birth/#:~:text=If%20a%20planned%20birth%20is,complications%20is%20generally%20very%20low.) – Stillbirth CRE  [Timing of Birth](https://rednose.org.au/article/timing-of-birth) – Red Nose | |  |
| Screen for stillbirth risk at term | |  | [Still Birth Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2022-10/stillbirth_clinical_care_standard_2022.pdf) – ACSQHC | |  |

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#### Primary driver: Application of the bundle elements

#### This part of the change package focuses on the provision of evidence-based practice during routine care, and change ideas relating to professional development

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| Secondary driver | Change ideas |  | Resources | Your team’s ideas |
| Routine professional development | Incorporate education and training on the five clinical interventions, shared-decision making and providing informed consent, | Local education on how to deliver each component of the bundle is essential to the success of the project and will enable staff to carry out all elements safely and effectively.  Ensuring informed consent is properly obtained is a legal, ethical and professional requirement on the part of all treating health professionals. It supports person-centred care and enables shared-decision making. | [Safer Baby Bundle – resources for clinicians](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/safer-baby-bundle-resources-for-clinicians/) – Stillbirth CRE  [Training and resources for health services (quit.org.au)](https://www.quit.org.au/resources/health-professionals/training-and-resources-health-services/)  [Every Week Counts - resources for clinicians](https://everyweekcounts.com.au/healthcare-professionals/)  [Safer Baby Bundle e-learning and masterclass](https://stillbirthcre.org.au/researchers-clinicians/education-and-workshops/safer-baby-bundle-e-learning-and-masterclass/) – Stillbirth CRE  [IMPROVE e-learning and workshops](https://stillbirthcre.org.au/researchers-clinicians/education-and-workshops/improve-elearning-and-workshops/) – Stillbirth CRE  [Informed consent in health care](https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf) - ACSQHC  [Shared decision making](https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making) – ACSQHC  [Using plain language in health information](https://pifonline.org.uk/resources/how-to-guides/using-plain-language-in-health-information/html-version/)  [Easy English](https://www.health.tas.gov.au/professionals/health-literacy/health-literacy-workplace-toolkit/written-communication/easy-english)  [The Power of Four Words: "What Matters to You?" | IHI - Institute for Healthcare Improvement](http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx)  [Delivering Great Care: Engaging Patients and Families as Partners | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx) |  |
| Create training videos for the five clinical interventions |  |  |  |
| Introduce daily SBC huddles in antenatal clinic, to gather feedback and share information |  |  |  |
| Incorporate teach-back skills | By using the ‘teach back’ technique throughout the care journey, clinicians will ensure that patients and carers understand the key messages which are necessary for the prevention of stillbirths.  This method ensures they can ask questions as part of the process and their health literacy does not impede them. They, in turn, are to apply these to the management of their pregnancy. | [Always Use Teach Back! | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx)  [Teach-back](http://teachback.org/research/) |  |
| Identify opportunities for in-the-moment teaching, reflection, and clinical reasoning development |  |  |  |

| Secondary driver | Change ideas |  | Resources | Your team’s ideas |
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| Every episode of care | **Bundle element 1: Promoting smoking cessation**  Screen for smoking behaviours using the Ask, Advise, Help brief advice intervention | Women who smoke during pregnancy should be supported to quit using evidence-based approaches, such as the three-step ‘Ask, Advise, Help’ (AAH) model. | [Primary Health Care Nursing | Quit Centre](https://www.quitcentre.org.au/nursing) - Quitline  [Supporting smoking cessation: a guide for health professionals](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation) – RACGP  [Smoking cessation care pathway](https://stillbirthcre.org.au/wp-content/uploads/2021/03/downloadsSmoking-Care-Pathway-1.pdf) – Quit, PSANZ, Stillbirth CRE  [Position statement: smoking – one of the most important things to prevent in pregnancy and beyond](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-1_Smoking-Cessation-Position-statement-1.pdf) – PSANZ and Stillbirth CRE  [Stillbirth Clinical Care Standard](https://www.safetyandquality.gov.au/standards/clinical-care-standards/stillbirth-clinical-care-standard) – ACSQHC |  |
| Refer to Quit services |  | [Quitline referral form](https://www.quit.org.au/referral-form/) |  |
| Include partners and other family members in screening and referral | Second-hand smoke can still pose significant stillbirth risk. Clinicians should offer the same advice and support to other smokers in the woman’s household, whenever possible. | [Still Birth Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2022-10/stillbirth_clinical_care_standard_2022.pdf) – ACSQHC  [Position statement: smoking – one of the most important things to prevent in pregnancy and beyond](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-1_Smoking-Cessation-Position-statement-1.pdf) – PSANZ and Stillbirth CRE |  |
| Share information with GPs | With consent from the woman | [Stillbirth Clinical Care Standard](https://www.safetyandquality.gov.au/standards/clinical-care-standards/stillbirth-clinical-care-standard) – ACSQHC |  |
| **Bundle element 2: Detection and management of fetal growth restriction (FGR)**  Screen all women for their risk of FGR | FGR is a key contributor to stillbirth. Assessing the risk of FGR as early as possible, and at each subsequent antenatal visit is an important step in timely detection. Clinicians should provide care as described in the Fetal Growth Restriction (FGR) Care Pathway. | [FGR Management Pathway](https://stillbirthcre.org.au/wp-content/uploads/2021/03/FGR-Care-Pathway_V2.0_May-2022.pdf) – Stillbirth CRE and PSANZ  [Still Birth Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2022-10/stillbirth_clinical_care_standard_2022.pdf) – ACSQHC  [Position statement: detection and management of fetal growth restriction in singleton pregnancies](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-2_Fetal-Growth-Restriction-Position-Statement-2.pdf) – PSANZ and Stillbirth CRE |  |
| Use a consistent technique for measuring symphyseal fundal height (SFH) | Using a standardised technique to measure SFH reduces variation in clinical practice and improve detection of FGR.  Health services may consider introducing credentialing of SFH measurement. | [Position statement: detection and management of fetal growth restriction in singleton pregnancies](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-2_Fetal-Growth-Restriction-Position-Statement-2.pdf) – PSANZ and Stillbirth CRE  [SFH technique video](https://vimeo.com/711466835/e8df8f1ae9) – Stillbirth CRE |  |
| Plot symphyseal fundal height (SFH) and estimated fetal weight (EFW) on growth charts |  | [Detection and management of fetal growth restriction in singleton pregnancies](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-2_Fetal-Growth-Restriction-Position-Statement-1.pdf) – Position statement, PSANZ and Stillbirth CRE |  |

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| Secondary driver | Change ideas |  | Resources | Your team’s ideas |
| When reported | **Bundle element 3: Management of decreased fetal movement**  Assess all women who report DFM as soon as possible | A woman who contacts her clinician or health service with concerns about a change in the frequency, strength or pattern of her baby’s movements should be offered timely assessment and care according to the Decreased Fetal Movement Care Pathway. | [DFM Care Pathway](https://stillbirthcre.org.au/wp-content/uploads/2021/03/DFM-Management-Pathway-1.pdf) – PSANZ and Stillbirth CRE  [DFM Clinical practice guideline](https://stillbirthcre.org.au/wp-content/uploads/2021/03/Element-3_DFM-Clinical-Practice-Guideline-1.pdf) – PSANZ and Stillbirth CRE  [DFM Resources](https://stillbirthcre.org.au/researchers-clinicians/download-resources/safer-baby-bundle-resources/decreased-fetal-movements-dfm-resources/) – Stillbirth CRE  [Reduction of late stillbirth with the introduction of fetal movement information and guidelines - a clinical quality improvement.](https://pubmed.ncbi.nlm.nih.gov/19624847/) |  |

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