

CONFIDENTIAL

**Hospital / Health Centre
Perinatal and Neonatal Death Reporting Form**



**Ministry of Health and Family
Maldives**

2010

The information contained in this form is ONLY for the use of MPMMRC and is SOLELY intended to be used to prevent maternal and perinatal deaths and to improve the services related to maternal and neonatal care

INSTRUCTIONS FOR USERS

This form must be completed for any perinatal and neonatal death that occurs in a hospital or a health centre. This form also must be filled with all available and applicable information on neonatal deaths that are brought dead.

<i>Perinatal death</i>	<i>- deaths that occur as a still birth or in the early neonatal period (<7 days of age)</i>
<i>Neonatal death</i>	<i>- death of a child up to and including 28 days of age</i>

*Health Centres may not complete the sections shaded grey.
All tertiary level hospitals have to complete all sections in the form*

NB: Please refer the information at the back when completing the questions which require additional information.

1. FACILITY DETAILS

Name of hospital / health centre	Atoll	Island
<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Mother's Details

Name	<input type="text"/>	Hospital /HC No.	<input type="text"/>	Please fill as applicable Even if mother is not admitted get the ANC information
Address	<input type="text"/>	Admission No.	<input type="text"/>	
Age	<input type="text"/> <input type="text"/>	Date of birth	<input type="text"/>	
		ANC Registration No (Hospital / HC)	<input type="text"/>	
		Registration No. (island)	<input type="text"/>	

3. BABY'S DETAILS

Name (if given) _____

Type of Death **→** *Still Brth* *Neonatal Death*

Hospital/HC No.	<input type="text"/>	Admission No.	<input type="text"/>	Gestational age at birth (weeks)	<input type="text"/> <input type="text"/>
Date of birth	<input type="text"/>	Time of birth	<input type="text"/> (am/pm)	Birth weight (grams)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of death	<input type="text"/>	Time of death	<input type="text"/> (am/pm)	Sex → <i>Male</i> <input type="checkbox"/> <i>Female</i> <input type="checkbox"/> <i>Ambiguous</i> <input type="checkbox"/>	

If multiple pregnancy **→** *Number of babies born*

4. OBSTETRIC HISTORY

4.1 Previous Obstetric History

Gravida Parity

Number of previous still births/ abortions

Number of sibling deaths if any

Sibling illnesses if known *Describe:*

Total TT immunization doses received (if known)

4.2 Obstetric History- Present Birth

4.2.1 Antenatal

Total no. of ANC Visits/ Checkups No. of TT immunization doses

Was there bleeding during pregnancy? Yes No

If 'Yes' what was the cause of bleeding (Tick as applicable)

Threatened abortion Placental abruption Placenta previa

Vasa previa Trauma Undetermined

Was hypertension present? Yes No

If 'Yes' (Tick as applicable)

Essential hypertension Chronic+Superimposed pre-eclampsia

Pre-Eclampsia Eclampsia

Other hypertension *Specify:*

Was diabetes present? Yes No

If 'Yes' (Tick as applicable) → Gestational diabetes Other diabetes

If 'gestational diabetes'

Details of medication:

Was any other maternal medical/ surgical problem present? Yes No

If 'Yes' (Tick as applicable)

Hypothyroidism *Hyperthyroidism*

Infection *Specify:*

Malignancy *Specify:*

Heart disease *Specify:*

Injury *Specify:*

Major abdominal surgery *Specify:*

Any others *List:*
1.
2.
3.

5. LABOUR, DELIVERY & POSTNATAL DETAILS

5.1 Details on birth labour and delivery

Was the death an unexplained intrauterine death? Yes No

When did the death occur?

Before onset of labour

During labour

Before birth (unknown time)

After birth

Was there rupture of membranes more than 12 hours prior to onset of labour? Yes No Unknown

Were there cord complications? Yes No

If 'Yes' describe

Was chorioamnionitis present? Yes No Unknown

If 'Yes' diagnosis was:

Pathological Clinical

If pathological:

Group B Streptococcus

Other bacterial

Other

Specify:

Level of hospital/health centre care received (Tick as applicable):

[Please indicate all places where care was received, where initial care was given and where referred to]

Initial care

- Tertiary hospital
- Private hospital
- Regional hospital
- Atoll hospital
- Health centre
- Health post
- Home
- Other

Specify:

Subsequent care

- Tertiary hospital
- Private hospital
- Regional hospital
- Atoll hospital
- Health centre
- Health post
- Home
- Other

Specify:

Referral

- Tertiary hospital
- Private hospital
- Regional hospital
- Atoll hospital
- Health centre
- Health post
- Home
- Other

Specify:

Onset of labour

Spontaneous Induced No labour

Mode of delivery

- Spontaneous vaginal Breech extraction Assisted vaginal
- Instrumental Caesarean Section
 - Forceps Emergency
 - Vacuum Elective

Presentation → Vertex Breech Cord Others

Specify:

Was there (tick as applicable) Oligohydramnios

Polyhydramnios

Others

Specify:

Who conducted the delivery?

- Nurse
- Nurse midwife
- Medical officer
- Obstetrician
- TBA(Foolhuma)
- CHW/FHW
- Other

Specify:

5.2 Postnatal details

Apgar Scores
(See instruction)

1 min	5 min	in 10 m
<input type="text"/>	<input type="text"/>	<input type="text"/>

Was the liquor meconium stained? Yes No

If 'Yes' was the baby → Vigorous Floppy

Was cord blood gas done? Yes No

If 'Yes' was the baby

pH _____ pCO₂ _____ pO₂ _____ Base Excess _____ Bicarbonate _____

Was neonatal resuscitation required? Yes No

Was neonatal resuscitation done in the labour room? Yes No

If 'Yes' specify (tick as applicable)

<input type="checkbox"/> Endotracheal tube suction	<u>Duration</u> _____ Min.	→	<u>Meconium aspirated?</u> Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Bag and mask ventilation	_____ Min.		
<input type="checkbox"/> Bag and tube ventilation	_____ Min.		
<input type="checkbox"/> External cardiac massage	_____ Min.		

Resuscitation medications (tick as applicable)

<input type="checkbox"/> Epinephrine	<u>Dose given</u> _____
<input type="checkbox"/> Normal saline	_____
<input type="checkbox"/> Naloxone	_____
<input type="checkbox"/> Sodium bicarbonate	_____
<input type="checkbox"/> Others	Specify: <input type="text"/>

Was assisted ventilation (apart from resuscitation) required?

If 'Yes' → Type of assisted ventilation (apart from resuscitation)

CPAP PPV Other

Specify:

Was any procedure performed? Yes No

Procedures performed if any **Reason**

<input type="checkbox"/> Partial exchange transfusion	_____
<input type="checkbox"/> Total blood exchange transfusion	_____
<input type="checkbox"/> Intercostal drainage	_____
<input type="checkbox"/> Aspiration	_____
<input type="checkbox"/> Central venous / arterial line insertion	_____
<input type="checkbox"/> Others (specify)	_____
_____	_____
_____	_____

Was any surgery performed? Yes No

If 'Yes':

Nutrition/feeding during hospital stay

Breastfeeding
 Tube feeding
 Spoon/ cup feeding
 Parenteral

6. DETAILS OF BABY

Maturity:

- Preterm** [gestational age <37 weeks] →
 Term [gestational age >37 weeks but <42 weeks]
 Post term [gestational age >42 weeks]

Most likely cause of pre-maturity:

Significant anthropometric measurements:

Head circumference _____ cm
 Crown heel length _____ cm

Others Specify:

Was there intra uterine growth restriction (IUGR)?

(Birth weight less than 10th percentile)

See growth percentile chart in reference information

Yes No

If 'Yes' (tick as applicable):

- Symmetric (formula)
 Asymmetric (formula)

Most probable cause of IUGR

- Idiopathic
 Placental pathology
 Intrauterine infections
 Nutritional
 Maternal medical problems →
 Others

Specify:

Specify:

Disorders of size

(Refer growth percentile charts)

- SGA (Small for gestational age - <10th percentile)
 LGA (Large for gestational age - > 90th percentile)

Specify

Birth/ genetic defects if any (See instructions)

- Cardiac
 Cranio-facial
 Chromosomal anomaly
 Gastro-intestinal
 Genital/Urinary
 Muscular skeletal
 Other defect

Any birth injuries present

Yes No

If 'Yes' (tick as applicable):

Fractures →

Specify:

Brachial plexus injury [Erb's/ Klumpke's]

Lacerations

Facial nerve injury

Other

Specify:

Placenta examined?

Yes No

Give details if any abnormality:

7. DETAILS ON NEONATAL DEATHS

7.1 Condition at admission (reporting health facility)

Brought dead Yes No

If 'Yes' was there any indication of abuse?

If 'Yes' describe

Vitals (Record) → RR _____ HR _____ BP _____ Temp. _____
SpO₂ _____

Was brought with O₂? Yes No

Was assisted ventilation required during transportation? Yes No

If 'Yes' Bag and mask Bag and tube

No. of hours of assisted ventilation _____ hrs

7.2 Condition during admission (reporting health facility)

Was there any morbidity during admission? Yes No

If 'Yes' (tick and specify as applicable):

Specify

Morbidity conditions if any (Refer instructions)

<input type="checkbox"/>	Respiratory	_____
<input type="checkbox"/>	Cardiovascular	_____
<input type="checkbox"/>	CNS	_____
<input type="checkbox"/>	Haematological	_____
<input type="checkbox"/>	GIT	_____
<input type="checkbox"/>	Infections	_____
<input type="checkbox"/>	Metabolic/ Endocrine	_____
<input type="checkbox"/>	Eyes	_____
<input type="checkbox"/>	Other(s)	_____

Was surfactant given? Yes No

If 'Yes' (tick as applicable) at: Delivery room
 Nursery/NICU

Who was the primary neonatal care provider?

- Nurse
 Nurse midwife
 Medical officer
 Paediatrician
 Neonatologist
 Obstetrician
 Anaesthesiologist
 TBA(Foolhuma)
 CHW/FHW
 Other

Specify:

Maternal medications given:
(List all – see instruction)

Anaesthesia given: Yes No

If 'Yes' specify:

8. CAUSE OF DEATH

8.1 Complete diagnosis at admission

8.2 Complete diagnosis at death

8.3 Obstetric cause of death (If still born/ IUD)

9. SIGNIFICANT FAMILY/ SOCIAL HISTORY OF MOTHER

Level of education (mother)

- Basic education (asaasee thauleem)
 Primary education (grades 1-7)
 Secondary education (grades 8-10)
 Higher secondary education (grades 11-12)
 Diploma /Degree & above

Marital status (mother)

- Married
 Divorced
 Single

Employment (mother)

- Employed
 Not employed

History of tobacco use /substance abuse in mother

Yes No

If 'Yes' (tick as applicable):

- Smoking
 Drug abuse

10. IN YOUR OPINION DID ANY OF THE FOLLOWING FACTORS CONTRIBUTE TO THE DEATH OF THIS PATIENT?

System	Example	Y	N	?	Specify
Personal/Family	Delay in woman seeking help				
	Declined treatment or admission				
	Other; specify				
Logistical systems	Lack of transport from home to health care facility				
	Lack of transport between health care facilities				
	Health service - Health service communication breakdown				
Facilities	Lack of facilities, equipment or consumables (drugs, infusion sets, blood, fluids etc.)				
Health personnel problems	Lack of human resources				
	Lack of expertise, training or education				
	Delays in Referral				
	Delays in appropriate action				

Comments on potential avoidable factors, missed opportunities and substandard care

Please note that substandard care includes inadequate monitoring as well as substandard management.

11. WHAT HAS YOUR INSTITUTION LEARNT FROM THIS CASE AND WHAT ACTIONS DO YOU ENVISAGE FROM THIS LEARNING PROCESS? (If applicable)

12. ANY OTHER RELEVANT/SIGNAFICANT INFORMATION REGARDING DEATH

State here:

<i>Form completed by:</i>	<i>Form checked by:</i>
Name:	Name:
Designation:	Designation:
Place:	Place:
Date:	Date:

REFERENCE INFORMATION FOR USERS

APGAR Scoring

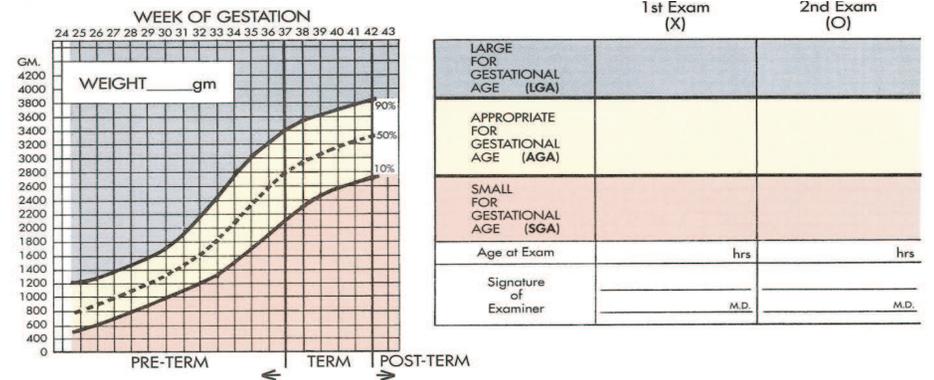
Sign	0	1	2
<i>Heart Rate</i>	Absent	Slow <100	>100
<i>Respiratory Effort</i>	Absent	Irregular, slow, weak cry	Good, strong cry
<i>Muscle Tone</i>	Limp	Some flexion of extremities	Well flexed
<i>Reflex Irritability</i>	No response	Grimace	Cry, sneeze
<i>Colour</i>	Blue, Pale	Body pink, extremities blue	Completely pink

Write the total scores observed in all the 5(five) parameter at 1 and 5 minutes after birth and repeat at 10 minutes if condition is not stabilised. Each item or parameter is given a score of 0, 1 or 2 based on the indicators as given in the table.

- Total scores of 0 to 3 —————> *Severe distress in adjusting to extra uterine life*
- Total scores of 4 to 6 —————> *Moderate difficulty in adjusting to extra uterine life*
- Total scores of 7 to 10 —————> *Absence of difficulty in adjusting to extra uterine life*

Assessment of birth weight related to gestational age

Classification of infants at birth by both *birth weight* and *gestational age* provides a more satisfactory method for predicting mortality risks and providing guidelines for management of the neonate than estimating gestational age or birth weight alone



- Appropriate for gestational age (AGA)* —————> *Weight between 10th and 90th percentile*
- Large for gestational age (LGA)* —————> *Weight above 90th percentile*
- Small for gestational age (SGA)* —————> *Weight below 10th percentile*

