End of life care, bereavement care and follow-up meetings with parents– extended examples of quality improvements implemented in trusts and health boards following PMRT review ordered by clinical improvement area

The issue with care identified	Service improvement(s) implemented
Care at diagnosis of death of the baby Poor compassionate care was being given to bereaved mothers/birthing people at the diagnosis of fetal loss.	Service improvements introduced with the Bereavement Midwifery Team. (Escalated to the Maternity Voices Partnership (MVP) Lead to discuss the issue with service users at MVP meetings to listen to our bereaved women. With the MVP Chair and a Bereaved Mother the risk management lead undertook a 15 step walk across Maternity and NICU/SCBU to review the women's journey and seek solutions. Risk management lead invited Bereaved Mother and MVP Chair and Co-Chair as guest speakers to the 'Bite Size Risk' management teaching for junior doctors
Bereavement suite Environment in maternity was unsuitable for caring for bereaved families. Lack of sound proofing in the bereavement suite so the occupants are able to hear noises of babies from labour ward *(Multiple survey respondents reported this issue)*	Maternity department was physically restructured to enable a suitable bereavement suite to be incorporated within the existing footprint. New bereavement suite was developed and moved off labour ward and is much more private. The room itself is set up so that we have a clinical side that is used for birthing and any assessments and then we have a side that is a bedroom with a small kitchenette area. The room also includes a bathroom which is wheelchair accessible/wet room. Partner is able to stay and also use the bed in the bedroom, friends and family are able to visit at any time. Service users were invited to the opening of the suite. Existing bereavement suite which was appropriately located other than noise was sound proofed *(Multiple respondent reported a version of this QI action was implemented; this is a combined answer from multiple respondents)*
Bereavement care questions Following the launch of our electronic patient record system, our bereavement checklist was not being filled-out in its entirety, therefore we were not sure what bereavement care had been provided.	We revised our bereavement checklist and made it more accessible so we can ensure the bereavement care provided is gold standard. We sent out communications and learning for staff to show where to find the checklist.

Bereavement care In multiple reviews we identified the need for better bereavement care	Using the evidence from PMRT reviews, by grading care as B/C where parents felt let down with their bereavement care, we were able to use this evidence to get more traction with the trust to obtain the resources to develop a bereavement team.
Lack of support following bereavement Lack of support/counselling for women and families following pregnancy loss/baby loss	All our bereaved families are referred for bereavement support and we now work on an 'opt out' basis Letter of invitation is sent for the family to make an appointment when they feel ready
Offer to take their baby home Parents were not always offered the opportunity to take their deceased baby home.	Stillbirth and neonatal death checklists have been updated to ensure parents are offered the opportunity to take their baby home following stillbirth or neonatal death and to ensure this is appropriately documented.
Offer to take their baby home Parents were not being asked if they wished to take their baby home.	New bereavement booklets supporting staff with paperwork and care plans for bereaved families, which specifically asks maternity staff if they have asked the parents if they wish to take their baby home. Bereavement training supporting maternity staff, regular staff updates with full time bereavement midwife, who is present on labour ward which has allowed this service to be offered as routine care, enabling staff to feel confident about what they are offering parents.
Palliative care arrangements There was no postnatal care pathway for women discharged from hospital when their babies are receiving palliative care in a hospice.	Change to local guidance and working relationship with local hospice to ensure women discharged from our hospital to the hospice would receive postnatal care from our community midwifery team, including care at home following discharge from the hospice.
Poor documentation of end of life care Poor documentation of end of life care leading to many responses in response to the PMRT questions during the review of 'unable to say'	End of life care bundle introduced which captures all aspects of care which is reviewed in a PMRT review.
Location of follow-up review After a stillbirth women were seen for a Joint MDT Consultant Obstetric PMRT Lead & Bereavement Midwifery Debriefing Clinic appointment about 12 weeks after their baby died. Women were seen in a seclude area at the back of the scanning department (away from other pregnant women in the antenatal clinic), in a room reserved to break bad news for women who had unexpected abnormal scan findings. However these Bereaved women regularly came in contact with pregnant women who attended for scanning.	Improved the patient experience for Bereaved women who returned to the hospital for a Postnatal Debriefing Clinic appointment with the Consultant Obstetric PMRT Lead and the Bereavement Midwifery Team by relocating the meeting room away from scanning and antenatal care.

Engaging parents in PMRT reviews Looking historically in the past we have not had a clear system in place for identifying key contacts and involving families in reviews	We developed a pathways to ensure parents were offered the opportunity to engage in the review process. We undertook staff training undertaken to improve staff awareness of the role and PMRT process. Improvement noted in family engagement and in early identification of the key contact.
Joint reviews of care from multiple providers Review of care across more than one care provider We had a low incidences of cross boundary working in the completion of PMRT reviews for those women who had care provided across different Health Boards.	Increased engagement with cross boundary risk teams which has led to an increase in joint PMRT reviews of care for those women with shared care across Health Boards.
Engaging parents in PMRT reviews It became clear that we were not making parents were unaware of the time scale in which PMRT review would take place as a consequence they did not understand the many steps involved in this prior to a debrief being arranged. Often parents felt they had been forgotten or had to chase debrief appointments when in fact the team were working within the time scales set for PMRT.	Parent Engagement Materials | PMRT | NPEU (ox.ac.uk) materials to support staff in Trusts and Health Boards with engaging bereaved parents have been adapted and are now provided to parents from their perspective. The review process is explained to the parents during week 1 - all steps of the process are explained, and a flow chart provided with anticipated dates for completion. This allow parents to be fully aware of the lengthy process ahead and the time scale in which they can expect the review to be completed. Engaging bereaved parents in the review process and including their views and feedback has enhanced the review process at ensuring that improvements have been identified and implemented.
Kleihauer test Kleihauer test missed as part of postnatal investigations	Currently liaising with the IT department to add as test to the EPR as part of the group of blood tests offered during bereavement care In the meantime: educating Midwives, using the maternity messages system and emails to all staff.
Placental histology Placentae were not being sent for histological examination	Education and created awareness through emails among the staff , reminding the indications for placental histology and updating the guideline posters in theatres