# The Sands Audit Tool for maternity services

## Caring for parents whose baby has died

RCM accredited

Sands
Stillbirth & neonatal death charity

*"The quality of care that bereaved parents receive has a profound effect on their wellbeing and that of their families, both now and in the future. Good care cannot remove the pain of their grief, but poor care makes everything worse."* Neal Long, Chief Executive, Sands

*"I will always remember the midwife who looked after us throughout the labour and when our beautiful son was born dead. She managed to make a terrible event into something that was also very precious. She delivered him with such love and care. With one exception, everyone we saw during that awful time was kind and supportive. Remembering their kindness has kept us going through the darkest times."* Mother

Further copies of this Audit Tool are available to download from the Improving Care section of the Sands website www.uk-sands.org/home

Written by Alix Henley and Judith Schott
Front cover image: Elliot Wildsmith's precious moments with his Mummy and Daddy. Elliot was stillborn on July 18th 2007.
Accredited by the Royal College of Midwives
Designed by Hotrod

# Introduction

Every day in the UK, 17 babies are stillborn or die shortly after birth: almost 6,500 babies die every year. Over two-thirds of these stillbirths and deaths occur in maternity units (CMACE 2010).

We know from listening to parents that the care that they receive around the time of their baby's death is extremely important. Sensitive, thoughtful care cannot take away the pain of their loss, but it may provide some comfort in the months and years to come. Conversely, memories of thoughtless or uncoordinated care at a time when they are particularly vulnerable can haunt parents for many years. Research confirms that good care can affect parents' long-term wellbeing and may prevent the need for costly intervention later (RCOG 2006; Swanson KM 1999; Moulder 1998; Leoni 1997).

Sands' recent survey of UK maternity care (Sands 2010) found that, in most maternity units, provision and the organisation of care for bereaved parents have improved greatly over the last few decades. Most of the units that responded were able to provide good care. However, in about 20 per cent of the units that responded, care was still poorly resourced and organised, and in others it was patchy. In addition, the fact that care in most units is good is of absolutely no help to those parents whose baby dies in a unit where care and resources are poor.

# The Sands Audit Tool

Sands has developed this Audit Tool to enable people who are responsible for commissioning and providing services to answer the question, "Is this unit giving good care and support to all parents whose babies die?"

Not all the improvements that may be identified require additional resources. In many cases, small organisational changes can make a huge difference to parents' experience of care. The audit may also identify some necessary improvements that carry major costs; these may be hard to implement in the current financial climate. However, this is not a reason to ignore them. Improvements may not be possible immediately, but they will never be made unless the need for them has been identified.

# What the Audit Tool covers

The Audit Tool covers the care given to all parents whose baby or babies have died at any stage during pregnancy or afterwards. It focuses particularly on those areas that we know are very important to parents: thoughtful care that recognises the huge significance of what has happened; staff who are able to support them; sensitive and clear communication; relevant information and time to make choices; privacy and consideration so that parents are not caused additional unnecessary hurt or distress; and care that is coordinated so that they do not fall into the gaps.

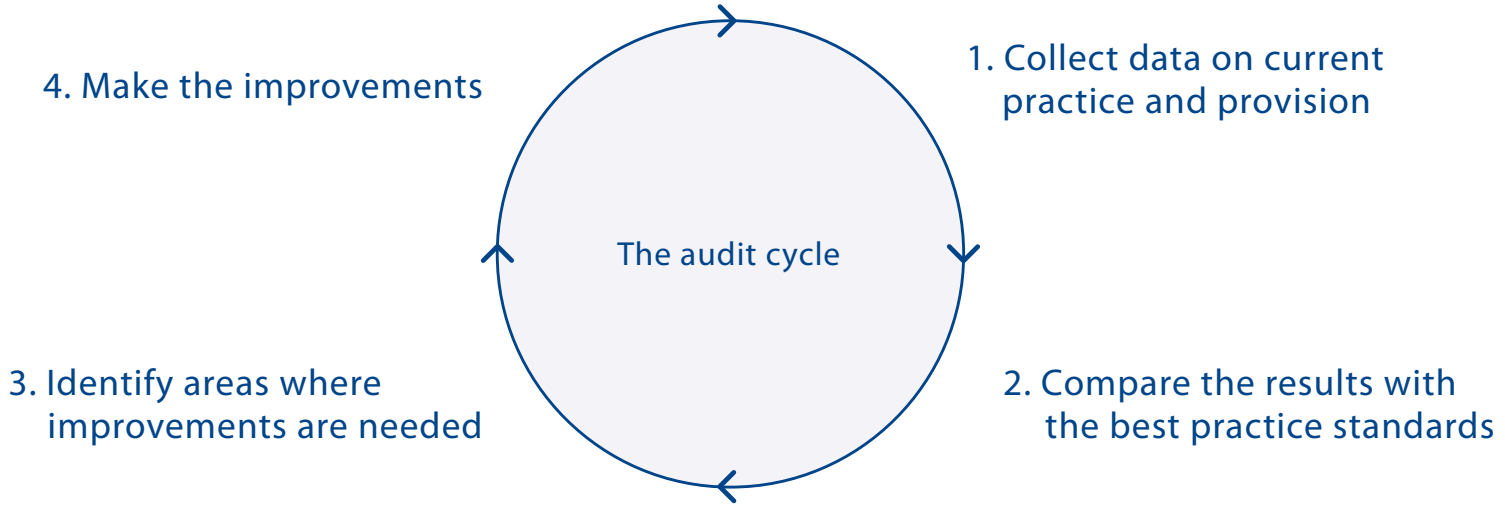
- Some of the standards in the Audit Tool – for example, those that refer to the place of care and to lengthy discussions with the mother – will not be appropriate when she is critically ill. However, they apply in all other cases.

- We have not included questions about the care given to mothers who have a late miscarriage outside the labour ward. Within the UK there is a great deal of variation in policies about the place of care for women who have a late miscarriage. Those women who are not cared for in a labour ward may be cared for in a variety of wards. It was therefore not possible to formulate useful questions that would cover the whole spectrum of possibilities. We have also not included specific items on late terminations for fetal abnormality.

- "Staff" in the Audit Tool refers primarily to midwives. Although doctors are particularly likely to be involved when problems are identified during pregnancy or labour and when a baby dies, most of the issues covered in this Audit Tool are not within their area of responsibility.

- Inevitably a few of the responses to items in the Audit Tool will be subjective – for example, whether there is adequate support for staff – but we believe that it is still useful to include these items since they are an essential part of good care.

# How to use the Audit Tool




Each commissioning body or maternity unit should decide how this Audit Tool can be used most effectively to improve care for bereaved parents.

For example, the audit may be carried out by the maternity unit manager(s), a bereavement care midwife, the Maternity Services Liaison Committee, and/or in conjunction with the local Sands group. Whoever carries it out, it is very important that the managers and senior staff of the unit support it and are committed to acting on the findings as far as possible.

To be most effective, the audit should be repeated every two to three years. Additional copies of the Audit Tool can be downloaded from the Improving Care section of the Sands website.

# Sands Audit Tool for maternity services

## Caring for parents whose baby has died

Unit.....

Trust/Health Board.....

Date audit started.....

Date audit completed.....

Lead person on the audit:

Title.....

Name (block caps).....

Signature.....

Names of audit group members (block caps)

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Next audit due.....

Additional notes .....

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| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| *1. Training and support for staff* | | | | | |
| 1.1 | There is a designated bereavement midwife in this unit. | | | | Sands 2007 pp. 159, 224 (no. 7) |
| 1.2 | All staff have had training and support to enable them to care sensitively and confidently for parents whose baby is dying or has died. | | | | Sands 2007, p. 229 (nos. 38, 39); RCOG 2008, 4.10, 20.21 |
| 1.3 | There is adequate and timely clinical and psychological support and mentoring for all staff at all levels (including doctors, ultrasonographers and other staff) who have been involved with parents whose baby has died. | | | | Sands 2007, p. 229 (nos. 38, 39); RCOG 2010, 11.4 |
| 1.4 | All staff have had training on how to communicate information effectively and sensitively. | | | | Sands 2007, p. 222; RCOG 2008, 22.1 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| *2. Ultrasound scans and care in the antenatal clinic when a lethal abnormality or an IUFD has been diagnosed* | | | | | |
| 2.1 | Real-time ultrasonography is always used to diagnose an intrauterine fetal death (IUFD). | | | | RCOG 2010, 4.1 |
| 2.2 | If the mother is unaccompanied, staff always offer to phone her partner, a relative or a friend. | | | | RCOG 2010, 4.2 |
| 2.3 | All staff involved in giving parents the results of screening tests, including ultrasonographers, are trained to give this information clearly and sensitively. | | | | Sands 2007, p. 77; RCOG 2008, 22.1 |
| 2.4 | All parents are offered written information to supplement discussions about the diagnosis and what will happen next. (For example, the Sands leaflet *When a baby dies before labour begins*.) | | | | Sands 2007 p. 74; RCOG 2010, 4.2 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 2.5 | The ultrasound department has at least one quiet dedicated room for counselling and discussions with parents. | | | | Sands 2007, p. 82; RCOG 2008, 4.4; RCOG 2000, 4.3.3 |
| 2.6 | The ultrasound department always has at least one member of staff available during antenatal clinic hours who is trained in counselling parents. | | | | Sands 2007, p. 82; RCOG 2000, 4.3.1 |
| 2.7 | The ultrasound department has a separate waiting area, away from other pregnant women, for parents who are waiting to confirm an abnormality or an IUFD. | | | | Sands 2007, p. 83 |
| 2.8 | Mothers who have been given a diagnosis of IUFD and then return home for any reason are always given a 24-hour phone number to contact. | | | | Sands 2007 p. 74; RCOG 2010, 4.2 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 2.9 | There is a fail-safe system for making sure that parents who are referred to another department or unit because a problem has been found or the baby has died, are expected and are received sensitively. | | | | Sands 2007, p. 82 |
| 2.10 | Whether the baby has already died, might live for a short time, or will be born critically ill, parents are always given enough time after receiving the diagnosis to reflect upon the information and their options, and to seek additional information and advice if they wish to, before they make their choices. | | | | Sands 2007, pp. 40, 98–9; RCOG 2008, 21.5, 22.5 |
| 2.11 | Whether the baby has already died, might live for a short time, or will be born critically ill, parents are always offered time and opportunities to discuss and plan the birth and how they would like it to be handled. | | | | Sands 2007, pp. 94, 98–9; RCOG 2008, 21.5, 22.5 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 2.12 | If it may be difficult to determine the sex of the baby at birth, the parents are always sensitively informed. | | | | RCOG 2010, 5.4 |
| *3. Care when a life-threatening or lethal abnormality has been diagnosed and the mother is continuing the pregnancy* | | | | | |
| 3.1 | Before the birth, parents are always offered an opportunity to see a neonatologist to discuss how their baby will be cared for. | | | | Sands 2007, p. 95 |
| 3.2 | Before the birth, a care plan for the baby is always drawn up and agreed with the parents. | | | | Sands 2007, pp. 90–1 |
| 3.3 | If the baby is likely to be admitted to a Neonatal Intensive Care Unit, the parents are always offered the opportunity to visit the unit before the baby is born. | | | | Sands 2007, p. 95 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 3.4 | There is a system to ensure that the mother has continuity of carer at all her antenatal appointments. | | | | Sands 2007, p. 95; RCOG 2008, 10.7, 11.4 |
| 3.5 | If continuity of carer is sometimes not possible for good reasons, there is a fail-safe system to make sure that all professionals who see the mother are fully informed about her situation. | | | | Sands 2007, p. 90; RCOG 2008, 11.4 |
| 3.6 | Since the parents are unlikely to want to attend standard antenatal classes, they are always offered individualised preparation for labour that is tailored to their needs. | | | | Sands 2007, p. 94 |
| *4. Communication between staff within the hospital when a mother has had an IUFD, a stillbirth or a neonatal death* | | | | | |
| 4.1 | The antenatal clinic staff are always informed of the baby's death. | | | | Sands 2007, p. 139; RCOG 2008, 22.2 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 4.2 | Any remaining antenatal appointments are always cancelled. | | | | Sands 2007, p. 139; RCOG 2008, 22.2 |
| 4.3 | The maternity unit has a comprehensive list of other likely departments that may need to be informed that the baby has died. | | | | RCOG 2010, 7.4 |
| 4.4 | All the relevant departments are always informed. | | | | RCOG 2010, 7.4 |
| *5. Communication with staff outside the hospital* | | | | | |
| 5.1 | The unit has a designated person who always ensures that the mother's GP and community midwife are accurately informed of what has happened within one working day:<br>• following the discovery of a serious problem or a fetal abnormality during pregnancy; | | | | Sands 2007, p. 226 (nos. 8, 20); RCOG 2008, 20.4 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 5.2 | • following a late miscarriage; | | | | Sands 2007, p. 226 (nos. 8, 20); RCOG 2008, 20.4 |
| 5.3 | • following the diagnosis of an IUFD; | | | | As above |
| 5.4 | • following a stillbirth; | | | | As above |
| 5.5 | • following a neonatal death in the maternity unit. | | | | As above |
| *6. Care on the labour ward* | | | | | |
| 6.1 | When there is time, parents are always offered opportunities to plan the birth and how they would like it to be handled. | | | | Sands 2007, p. 227 (no. 25); RCOG 2010, 6.4; RCOG 2008, 20.5 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 6.2 | Once she is in established labour, every woman has an experienced midwife who looks after her throughout her labour and birth. | | | | Sands 2007, p. 139; RCOG 2008, 22.2 |
| 6.3 | Less experienced midwives are given opportunities to care for women alongside experienced midwives in order to develop their skills and confidence. | | | | Sands 2007, p. 227 (no. 5); RCOG 2010, 6.4 |
| 6.4 | Regional anaesthesia is available for all women. | | | | Sands 2007, pp. 98–9 |
| 6.5 | All staff are able to give the mother sensitive and supportive care during labour and the birth, and to deliver and handle the baby sensitively. | | | | RCOG 2010, 6.4; RCOG 2008, 30.11 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 6.6 | There are one or more dedicated rooms on the labour ward with en suite toilets and showers for mothers whose baby has died or will die, where they cannot hear other mothers and babies. | | | | |
| 6.7 | A mother whose baby has died or will die can always stay in a dedicated room for both the labour and the birth. | | | | Sands 2007, pp. 101, 124–34; RCOG 2008, 4.10, 20.2; NICE 2007, 1.3.1.4 |
| 6.8 | There are enough of these dedicated rooms for the number of late miscarriages, stillbirths and neonatal deaths in this unit. | | | | RCOG 2010, 6.6 |
| 6.9 | Parents whose baby is expected to die shortly after birth are given as much time as they want to be with their baby both before and at the time of the death. | | | | |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 6.10 | All staff are able to offer parents opportunities to see and hold their baby and to create memories. | | | | Sands 2007 pp. 101, 124–34; NICE 2007, 1.3.1.4 |
| 6.11 | When a baby has died, all staff use the Sands form (or a modified version of the Sands form) to record discussions and decisions about seeing and holding the baby (see page 41 for more information). | | | | |
| 6.12 | All staff are able to take the baby's hand and footprints if the parents want. | | | | Sands 2007 pp. 101, 124–34; NICE 2007, 1.3.1.4 |
| 6.13 | All staff are able to take sensitive photos of the baby and also to support parents who want to take their own photos. | | | | Sands 2007 pp. 101, 124–34; NICE 2007, 1.3.1.4 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 6.14 | A staff member always asks parents if they would like her/ him to contact another family member on their behalf. | | | | Sands 2007 pp. 101, 124–34; NICE 2007, 1.3.1.4 |
| 6.15 | The chaplaincy and the maternity unit have arrangements with elders of all the major faiths and with non-religious spiritual organisations whom they can contact to provide guidance and support for parents. | | | | RCOG 2010, 8.5 |
| 6.16 | A member of staff always asks parents if they would like her/ him to contact a suitable chaplain, priest or other religious person (or to ask the chaplaincy to contact a member of the parents' faith). | | | | Sands 2007, pp. 99, 186, 225 (no. 12); RCOG 2010, 8.5 |
| 6.17 | All staff know that they should (with the mother's consent) mark her notes with a Sands teardrop sticker (or equivalent) (see page 41 for more information). | | | | Sands 2007, p. 99 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 6.18 | Partners and other family members are always able to get food and hot drinks (even if only from a machine) 24 hours a day. | | | | Sands 2007, p. 124 |
| 6.19 | There are toilets and washing facilities for both male and female partners and other family members near the labour ward. | | | | Sands 2007, p. 100 |
| *7. Care after the birth: late miscarriage and stillbirth* | | | | | |
| 7.1 | Until they go home, all parents are always cared for in a dedicated room, with an en suite toilet and shower, where they cannot hear other babies. | | | | Sands 2007, p. 227 (no. 25); RCOG 2010, 6.4; RCOG 2008, 20.5 |
| 7.2 | Each dedicated room has a double bed (or an extra single bed) so that the mother's partner or companion can stay overnight. | | | | Sands 2007, p. 135; RCOG 2010, 6.4; RCOG 2008, 20.5 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 7.3 | There are enough dedicated rooms for the number of late miscarriages, stillbirths and neonatal deaths in this unit. | | | | Sands 2007, p. 227 (no. 25); RCOG 2008, 20.5 |
| 7.4 | All the dedicated rooms are large enough to accommodate other family members who want to visit. | | | | Sands 2007, p. 135 |
| 7.5 | A member of staff always asks parents if they would like her/him to contact a suitable chaplain, priest or other religious person (or to ask the chaplaincy to contact a member of the parents' faith). | | | | Sands 2007, p. 227 (no. 26) |
| 7.6 | When a mother leaves the unit, she is given clear information about how to care for herself physically, and about the importance of having a postnatal check-up. | | | | Sands 2007, pp. 138, 203 (no. 26) |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 7.7 | The unit has a book of remembrance for parents, relatives and friends. | | | | Sands 2007, p. 197; RCOG 2010, 8.5 |
| 7.8 | When parents leave the unit, they are given clear information about how they can arrange to come back to see their baby if they want to. | | | | |
| *8. Taking the baby's body home* | | | | | |
| 8.1 | Staff always offer parents the option of taking their baby's body out of the unit. | | | | Sands 2007, pp. 142–3 |
| 8.2 | All parents who take their baby's body out of the unit are given clear information about how to look after the body. | | | | Sands 2007, p. 143 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 8.3 | All parents who take their baby's body out of the unit are given a form confirming their right to do so, in case anyone raises concerns (see page 41 for more information). | | | | Sands 2007, p. 227 (no. 27) |
| *9. Post mortem examinations* | | | | | |
| 9.1 | All parents whose baby dies are offered a post mortem. | | | | RCOG 2010, 5.6; RCPCH 2002, 4.3 |
| 9.2 | All staff who seek consent/ authorisation for a post mortem are trained to do so, understand what a post mortem entails, understand the benefits of a post mortem, and are able to answer parents' questions. | | | | Sands 2007, pp. 165–8; RCOG 2010, 5.6; HTA 2009, Code 3, p. 89 |
| 9.3 | All parents are offered written back-up information about post mortems that is specifically suitable for a perinatal death. | | | | Sands 2007, pp. 165–6; RCOG 2010, 5.6; HTA 2009 Code 3, p. 89 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 9.4 | All post mortems on babies are carried out by a specialist perinatal pathologist. | | | | Sands 2007, p. 168; RCOG 2010, 5.6; RCPCH 2002, 7; RC-Path 1995 |
| 9.5 | When babies' bodies are transferred to another unit for post mortems, they are returned within ten working days (earlier if possible), except in special cases. | | | | Sands 2007, p. 169 |
| 9.6 | Post mortem results are always available within ten to twelve weeks of the birth. | | | | |
| 9.7 | All parents who have consented to a post mortem are able to discuss the results with a senior member of staff within twelve weeks of the birth. | | | | Sands 2007, pp. 206–7 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 9.8 | The pathologist is available to speak (face-to-face or by phone) to parents who have questions or specific requests about the post mortem. | | | | Sands 2007, p. 167 |
| 9.9 | There is provision for an urgent post mortem if, for cultural or religious reasons, the parents want to hold the funeral as soon as possible after the death. | | | | Sands 2007, p. 164 |
| *10. Registration* | | | | | |
| 10.1 | All parents whose baby is stillborn, or was born alive and then died, are given verbal information about how, when and where to register the stillbirth or the birth and death of their baby. | | | | Sands 2007, p. 175 |
| 10.2 | All parents whose baby is stillborn, or was born alive and then died, are given written information about how, when and where to register the stillbirth or the birth and death of their baby. | | | | Sands 2007, p. 175 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| *11. Funerals* | | | | | |
| 11.1 | All staff are able to give the parents verbal information about the funeral arrangements that the hospital offers. | | | | Sands 2007, pp. 182–7 |
| 11.2 | There is a clear and consistent local policy on the sensitive disposal of fetal tissue. | | | | Sands 2007, p. 228; RCOG 2008, 4.8 |
| 11.3 | All staff understand that the parents can choose to organise the funeral themselves and understand what the parents need to do. | | | | Sands 2007, pp. 182–7 |
| 11.4 | All parents are given good written back-up information about the funeral options available to them. | | | | Sands 2007, pp. 182–3; RCOG 2010, 8.5 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 11.5 | There is adequate provision for hospital funerals for members of the minority religions represented in the local catchment area. | | | | Sands 2007, pp. 184–8 |
| 11.6 | Burial (rather than cremation) is available for all those parents whose religion and/or culture require it. | | | | Sands 2007`, pp. 184–8 |
| 11.7 | If shared graves are used, the parents are informed in advance and are also told about any restrictions, eg, about placing memorials on a shared grave. | | | | Sands 2007, p. 185 |
| 11.8 | If a shared grave is used, the grave is always covered with a lockable grave cover until it is finally closed and the ground is reconstituted. | | | | Sands 2007, p. 189 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 11.9 | The requirement for the use of a lockable grave cover on a shared grave is included in all the unit's contracts with cemeteries. | | | | Sands 2007, p. 189 |
| 11.10 | All the unit's contracts with local funeral directors, cemeteries and crematoria specify that all babies' funerals must be handled sensitively and respectfully. | | | | Sands 2007, pp. 187–90 |
| 11.11 | One or more members of staff who regularly provide care for bereaved parents have input into all the unit's contracts. | | | | Sands 2007, p. 187 |
| 11.12 | A well-informed member of staff monitors the quality of contract funerals at least once a year. | | | | Sands 2007, p. 187 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| *12. Written back-up information for parents* | | | | | |
| 12.1 | There is a fail-safe system to make sure that no parent whose baby has died at any stage in pregnancy, or during or after birth, receives a Bounty Pack (or a similar pack) in hospital, nor subsequent Bounty mailings. | | | | Sands 2007, p. 224, item 5 |
| 12.2 | All parents whose baby dies are given the details of the Baby Mailing Preference Service so that they can stop other mailings of baby products etc (see page 41 for more information). | | | | Sands 2007, p. 139 |
| 12.3 | All parents whose baby dies are given a copy of the leaflet *Late miscarriage, stillbirth and neonatal death: what financial help is available?* produced by the Money Advice Service (see page 41 for more information). | | | | Sands 2007, p. 224, item 5 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
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| 12.4 | All parents whose baby dies are given written details of national and local sources of support and organisations such as Sands, BLISS, the Miscarriage Association, ARC (Antenatal Results and Choices), and the CBC (the Child Bereavement Charity). | | | | Sands 2007, p 210; RCOG 2008, 20.6 |
| *13. Postnatal check-up appointments* | | | | | |
| 13.1 | All available results are collected and are to hand before the appointment. | | | | RCOG 2010, 9.1 |
| 13.2 | All bereaved mothers attending the unit for a postnatal check-up are invited to wait in a separate waiting area, away from other mothers and babies. | | | | Sands 2007, p 208 |
| 13.3 | There is a fail-safe system for making sure that all staff who see a bereaved mother at her postnatal check-up know that her baby has died. | | | | Sands 2007, pp 206–7 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| *14. Care in subsequent pregnancies and births* | | | | | |
| 14.1 | A mother whose baby has died, and her partner, are always offered extra support and monitoring in each subsequent pregnancy. | | | | Sands 2007, pp 214–16 |
| 14.2 | A mother whose baby has died, and her partner, are always offered continuity of carer in each subsequent pregnancy. | | | | Sands 2007, pp 214–16 |
| 14.3 | The notes of a mother whose baby has died are always (with her consent) marked with a Sands teardrop sticker or equivalent in all subsequent pregnancies. | | | | Sands 2007, p 216 |
| 14.4 | A mother whose baby has died, and her partner, are always offered individual discussion and preparation for each subsequent labour and birth so that their specific needs can be met. | | | | Sands 2007, pp 216–17 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 14.5 | A mother whose baby has died, and her partner, are always offered extra support and monitoring for all subsequent babies. | | | | Sands 2007, pp 217–18 |
| *15. Care for parents whose first language is not English* | | | | | |
| 15.1 | Staff can always call on a professional interpreter when a problem is identified in the antenatal clinic or ultrasound department. | | | | Sands 2007, p 225 (nos. 10, 11); NICE 2010, 1.3.10; RCOG 2008 3.7, 7.3, 22.6 |
| 15.2 | Staff can always call on a professional interpreter when a problem is identified in the labour ward. | | | | Sands 2007, p 225 (nos. 10, 11); NICE 2010, 1.3.10; RCOG 2008 3.7, 7.3, 22.6 |
| 15.3 | If no professional interpreter is available, staff can always use a telephone interpreting service. | | | | Sands 2007, p 60; RCOG 2008 3.7, 7.3, 22.6 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 15.4 | All staff understand that, even if the mother's partner speaks some English, they should always offer to call an interpreter when a problem is diagnosed antenatally or in labour, or a baby dies. | | | | Sands 2007, p 50; NICE 2010, 1.3.10; RCOG 2008 3.7, 7.3, 22.6 |
| 15.5 | All staff understand that, except in the most extreme emergencies, it is not acceptable to use a child to interpret when a problem is diagnosed during pregnancy, a mother is in labour, or a baby dies. | | | | Sands 2007, p 60–1; NICE 2010, 1.3.10; RCOG 2008 3.7, 7.3, 22.6; CEMACH 2004 p 47 |
| 15.6 | All interpreters who may be called when a problem is diagnosed or a baby dies have had additional training to prepare them for this work. | | | | Sands 2007, pp 55–7; RCOG 2008, 23.4 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 15.7 | All interpreters who may be called when a problem is diagnosed or a baby dies have access to support and mentoring. | | | | Sands 2007, pp 55–7 |
| 15.8 | More time and flexibility are allowed for antenatal and other appointments in which an interpreter is used. | | | | NICE 2010, 1.3.4 |
| 15.9 | All staff have had training in communicating with people who speak little or no English. | | | | Sands 2007, p 225 (no. 11) |
| 15.10 | All staff have had training in working with professional interpreters. | | | | Sands 2007, p 225 (no. 11) |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 15.11 | All staff have had training in working with informal interpreters (family members etc). | | | | Sands 2007, p 225 (no. 11) |
| *16. Care for parents with hearing or visual impairments or learning difficulties* | | | | | |
| 16.1 | Staff can always call on a trained signer when a problem is identified in the antenatal clinic. | | | | Sands 2007, pp 62–3; RCOG 2008, 22.7 |
| 16.2 | Staff can always call on a trained signer when a problem is identified in the labour ward. | | | | Sands 2007, p 62; RCOG 2008, 22.7 |
| 16.3 | All staff have had training in working with signers. | | | | Sands 2007, p 62 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 16.4 | All staff understand how to give good care and support to a mother or her partner who has a hearing impairment. | | | | Sands 2007, pp 63–4; RCOG 2008, 3.9 |
| 16.5 | All staff understand how to give good care and support to a mother or her partner who has visual impairments. | | | | Sands 2007, pp 63–4; RCOG 2008, 3.9, 22.7 |
| 16.6 | All staff understand how to give good care and support to a mother or her partner who has learning difficulties. | | | | Sands 2007, p 12; RCOG 2008, 3.9, 22.7 |
| 16.7 | Information is provided in a form that is accessible to parents who have additional needs, such as those with physical, cognitive or sensory disabilities. | | | | RCOG 2008, 3.7, 22.7 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| *17. A seamless process of care* | | | | | |
| 17.1 | There is a designated member of staff who is responsible for overseeing and co-ordinating the whole experience of care for parents whose baby dies – from the moment the death is suspected or confirmed until the parents leave the unit. | | | | Sands 2007, pp 45, 224 (no. 7) |
| 17.2 | There is a designated member of staff who is responsible for monitoring maternity unit systems, policies and protocols to ensure that they are consistent and ensure the best possible care for all parents. | | | | RCOG 2008, 20.1 |
| 17.3 | The unit has formal and informal ways of getting feedback on the care that bereaved parents have received through, for example, local support groups and interviews with individual parents. | | | | Sands 2007, p 223 |

| | Standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| 17.4 | Special efforts are made to get the views of bereaved parents of minority cultures and faith groups, as well as of hard-to-reach parents who are unlikely to be represented by local voluntary groups. | | | | Sands 2007, p 223, item 1 |
| *18. Reviewing care* | | | | | |
| 18.1 | All stillbirths are reviewed in a multi-professional meeting using a standardised approach to analysis for sub-standard care and means of future prevention. The results of the discussion are recorded in the mother's medical notes and discussed with the parents. | | | | RCOG 2010, 11.2 |
| 18.2 | All neonatal deaths are included in regular audit/ case reviews. | | | | BAPM 1998, 6.1 |

# Sources and references


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CEMACH (2004) *Why Mothers Die 2000–2002: The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom* CEMACH/CMACE, London http://www.cmace.org.uk/getattachment/8bea058d-d476-4813-baa8da57df544551/Why-Mothers--Die-2000---2002.aspx (Accessed 29 December 2010)

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Sands (2007) *Pregnancy Loss and the Death of a Baby: guidelines for professionals* Sands, London

Sands (2010) *Bereavement Care Report 2010: survey of maternity units and the care they provide to parents whose baby dies before, during or shortly after birth* Sands, London

Swanson KM (1999) Effects of caring, measurement, and time on miscarriage impact and women's well-being. *Nursing Research* 48: 288–98

# Items referred to in the Audit Tool

## Available from Sands

- **Publications**

  **Bereavement Care Report 2010: survey of maternity units and the care they provide to parents whose baby dies before, during or shortly after birth**
  Can be ordered by phone from Sands and also ordered or downloaded from the Improving Care section of the Sands website: www.uk-sands.org > Improving Care > News and information for health professionals.

  **Pregnancy Loss and the Death of a Baby: guidelines for professionals**
  Can be ordered by phone, or online from the Sands website: www.uk-sands.org > Publications > Books.

  **Leaflets for parents, family members, parents and other people** can also be ordered by phone or through our online shop on the Sands website.

- **Other items**

  **Sample form to give to parents who take the baby's body out of the hospital**
  Downloadable from http://www.uk-sands.org/Improving-Care/Resources-for-health-professionals/Forms-and-certificates-to-download.html (Form 1).
  Also in the Sands Guidelines (see above).

  **Sample form for recording discussions about creating memories**
  Downloadable from http://www.uk-sands.org/Improving-Care/Resources-for-health-professionals/Forms-and-certificates-to-download.html (Form 7).
  Also in the Sands Guidelines (see above).

  **Sands teardrop stickers** can be ordered online from http://www.uk-sands.org/Improving-Care/Resources-for-health-professionals/Sands-teardrop-stickers.html.

## Available from other organisations

**Baby Mailing Preference Service (BMPS)**
DMA House, 70 Margaret Street, London W1W 8SS
Tel: 020 7291 3310
Fax: 020 7323 4226
Email: bmps@dma.org.uk
Web: www.mpsonline.org.uk/bmpsr/

**Money Advice Service** (previously Moneymadeclear)
*Late miscarriage, stillbirth and neonatal death: what financial help is available?*
Can be ordered from: www.moneyadviceservice.org.uk/parents > Do you work with families? > Order form – bereaved parents' leaflets
(**Note:** Before April 4th 2011, use this web address: http://www.moneymadeclear.org.uk/parents)

*"Everyone we came in contact with that night, the nurse, the registrar, the consultants, they were so fantastic. They took time to talk to me. And they really showed how upset they were as well."* Mother

*"I never thought that the staff would care so beautifully for a baby that had died. Seeing her dressed in proper baby clothes and handled so gently was very comforting."* Mother

# About Sands

Sands, the stillbirth and neonatal death charity, was founded in 1978 by a small group of bereaved parents devastated by the death of their babies, and by the total lack of acknowledgement and understanding of the significance and impact of their loss.

Since that time we have supported many thousands of families whose babies have died, offering emotional support, comfort and practical help.

Sands today operates throughout the UK and focuses on three main areas of work:

### We support anyone affected by the death of a baby

Bereavement support is at the core of everything we do. Some of the services that we offer include:

- Helpline for parents, families, carers and health professionals
- UK-wide network of support Groups with trained befrienders
- Online forum and message boards enabling bereaved families to connect with others
- Website and a wide range of leaflets, books and other resources.

### We work in partnership with health professionals to try to ensure that bereaved parents and families receive the best possible care

We undertake a comprehensive programme of training, workshops and talks for health professionals based on the Sands Guidelines which give practical guidance on how to meet parents' needs and provide good care.

### We promote and fund research that could help to reduce the loss of babies' lives

In spite of medical advances, the shocking reality is that each day in the UK there are ten babies who are stillborn and seven who die within the first 28 days of life. Through our Why17? campaign, we are raising vital funds for research, while challenging the Government to address these individual tragedies as a matter of urgency and priority.

We depend on the extraordinary energies of our supporters to raise the vital funds that we need to deliver the wide range of services that we offer.

If you would like any further information or support please contact us or visit our website.


| | | |
|---|---|---|
| **Support:** | **020 7436 5881** | **helpline@uk-sands.org** |
| **Enquiries:** | **020 7436 7940** | **info@uk-sands.org** |
| **Website:** | **www.uk-sands.org** | **www.why17.org** |
| **Write to us:** | **Sands, 3rd Floor, 28 Portland Place, London W1B 1LY** | |




Charity Registration Number 299679 | Company Limited by Guarantee Number 2212082

# Updates to the Sands Audit Tool for maternity services: caring for parents when a baby has died – May 2014

The first edition of the *Sands Audit Tool for maternity services* was published in 2012. The updated and additional standards listed below reflect issues that have emerged since then, mainly from our work on the Sands *Post mortem consent package* (Sands 2013) and *Listening to parents* (Redshaw et al 2014). A PDF of the Audit Tool (first edition) plus this update can be downloaded from the Resources section of the Sands website: www.uk-sands.org.

Sands is currently producing a second edition of the Audit Tool, integrating the additions and updates below into the Tool in the correct order. This will not be available from the Sands shop but will be downloadable from the Sands website.

| Item | New or updated standard | Answer | Action required | By whom / By when / Review date | Reference |
|---|---|---|---|---|---|
| *2: Ultrasound scans and care in the antenatal clinic when a lethal abnormality or an IUFD has been diagnosed* | | | | | |
| 2.3b (new) | When an IUFD, or a serious or lethal abnormality, is suspected by a midwife or an ultrasonographer, every attempt is made to get a doctor to check, and where necessary to confirm, the diagnosis as soon as possible. | | | | Sands 2007, p. 81 |
| *6: Care on the labour ward* | | | | | |
| 6.2 (updated) | Once she is in established labour, every woman has an experienced midwife who looks after her throughout her labour and the birth. A woman (and her partner) are never left alone during labour unless the mother or couple want time to themselves. | | | | Redshaw et al 2014, p.25 |

| Item | New or updated standard | Answer | Action required | By whom / By when / Review date | Refer-ence |
|---|---|---|---|---|---|
| *9: Post mortems* | | | | | |
| 9.1 (updated) | All parents whose baby dies are offered a post mortem. When consent/authorisation for PM is discussed with parents, they are given clear and honest information about when their baby will be returned for the funeral, and when they will get the results. | | | | Sands 2013, p. 11 |
| 9.5 (updated) | Arrangements for transferring babies' bodies to and from another unit for post mortem take into account the possible effect of delays on the quality of the findings, as well as the distress caused to bereaved parents. The maximum time the baby's body is away from the sending hospital is one week, except in special cases. | | | | Sands 2013, p. 11 |
| 9.6 (updated) | Post mortem results are always received by the referrer within a maximum of six weeks (60% of results) or eight weeks (90% of results) from the time when the pathologist received the baby's body, unless a specialist referral opinion (eg, neuropathology) or very complex metabolic or genetic testing are required.<br>To reduce delays, post mortem results are emailed to a named person in the relevant department at the sending hospital who has an NHS.net email account. A paper copy is also sent. | | | | (NHS Eng-land 2013 P. 7) |

| Item | New or updated standard | Answer | Action required | By whom / By when / Review date | Refer-ence |
|---|---|---|---|---|---|
| 9.7 (updated) | All parents who have agreed to a post mortem are able to discuss the results within two (or at most three) weeks of the results being received by the referrer. This discussion is with a senior doctor who is well-informed about the case. | | | | Sands 2013 |
| 9. 7b (updated) | If a specialist referral opinion or very complex metabolic or genetic testing is required and it will take more than eight weeks for the results to reach the referrer, an interim report, summarising the information that is currently available and indicating the outstanding information, is sent to the referrer as soon as possible so that he/she can discuss these results with the parents. | | | | (NHS Eng-land 2013 P. 7) |
| *11: Funerals* | | | | | |
| 11.13 (new) | All the unit's contracts with crematoria and/or funeral directors specify that every effort must be made to produce ashes, and that everything that is left following the cremation of a single baby or fetus must be offered to the baby's parents. If this is not possible, the unit does its best to find another crematorium that will try to offer ashes. If none of this is possible, parents are always told in advance that there will be no ashes so that they can decide whether they want to make other arrangements. | | | | |

| Item | New or updated standard | Answer | Action required | By whom / By when / Review date | Refer-ence |
|---|---|---|---|---|---|
| 11.14 (new) | All the unit's contracts with crematoria and/or funeral directors specify that they will inform a designated member of the hospital staff when ashes are available for collection by the parents. This staff member is then responsible for informing the parents, and also for letting the crematoria and/or funeral directors know if the parents do not want the ashes. | | | | |
| 11.15 (new) | All parents who have agreed to a hospital funeral are offered sensitively worded written confirmation of the arrangements, including, as relevant: *if the baby will be buried*, whether this will be in a shared or individual grave, and any restrictions about what can be placed on the grave; *if the baby will be cremated*, whether this will be a shared or individual cremation, and whether or not the parents will be offered ashes. Both the parents(s) and the health professional who discusses arrangements with them sign and date this document. | | | | |

## References


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Redshaw M, Rowe R and Henderson J (2014) *Listening to parents: the experience of women and their partners after stillbirth or the death of their baby after birth* National Perinatal Epidemiology Unit, Oxford www.npeu.ox.ac.uk/downloads/files/listeningtoparents/report/Listening%20to%20Parents%20Report%20-%20March%202014%20-%20FINAL%20-%20PROTECTED.pdf

Sands (2013) *Guide for consent takers: seeking consent/authorisation for the post mortem examination of a baby*. This is part of the Sands Post mortem consent package. Hard copies of the *Guide* can be ordered from the Sands shop http://shop-sands.org/shop/ or downloaded from the Human Tissue Authority website www.hta.gov.uk/licensingandinspections/sectorspecificinformation/postmortem/perinatalpostmortem/thesandsperinatalpostmortemconsentpackage.cfm



Alix Henley and Judith Schott. Sands May 2014