Please note this document is an extract from the pathway to be used to record your self assessment. Please use the [Miscarriage, Molar and Ectopic Pathway](https://www.nbcpscotland.org.uk/miscarriage/) for all other purposes. NBCP Scotland’s self assessment tools are designed to help boards, units and services to get ready to join our early adopters who are piloting the 5 bereavement care pathways or to prepare for the national rollout. The tool can be completed individually or by a group of staff. For each item, please say if you are able to do this by putting Y for yes, N for no, P for partly. If something is not relevant to your role, unit or service, you can put NA.

|  |  |
| --- | --- |
| **Job roles(s)** |  |
| **Unit(s) or service** |  |
| **Completed by** |  |

A. When a pregnancy issue is suspected

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Some women’s initial contact will be with paramedics, GPs and triage staff. Acknowledge the anxiety they may feel, listen and communicate sensitively, keep to known facts and answer questions within the scope of your practice.
 |  |  |
| 1. Wherever possible, prior to speaking with the woman, familiarise yourself with her history and any previous pregnancies or pregnancy loss.
 |  |  |
| 1. When seeking consent from the woman for a scan or another examination or test, sensitively explain the potential need for a second opinion and/or repeat scan.
 |  |  |
| 1. Be aware that the woman and partner may be anticipating challenging news because of signs or symptoms, an earlier assessment, a letter or phone call (e.g., re molar pregnancy) or a previous pregnancy. However, for many the news will come as a complete shock.
 |  |  |
| 1. Do not make assumptions about how the woman and partner feel about the pregnancy or the news – communicate empathically and follow their lead on terminology and language.
 |  |  |
| 1. If you suspect or identify a problem on examination and need to consult or confirm with a colleague outside the room, explain this before you leave the room. Be aware of your body language and non-verbal signals and be sensitive to the woman’s or partner’s reaction.
 |  |  |
| 1. Find a quiet and private place to deliver the news and/or to explain it further. This might mean giving the news in the scan room but explaining next steps elsewhere.
 |  |  |
| 1. If the woman is alone for the diagnosis, ask if she would like someone else to be present for further explanation.
 |  |  |
| 1. Share the known facts about the diagnosis and make sure the woman and her partner know what will happen next.
 |  |  |
| 1. Use clear, straightforward language. Avoid medical terms, abbreviations (e.g. ERPC) or euphemisms (e.g. ‘not in your tummy’).
 |  |  |
| 1. If the news is being given at an ultrasound scan, ask the woman and partner if they want you to show them what you have seen. Ask the woman if she would like to get dressed and sit up or prefer to see the screen while you explain the findings.
 |  |  |
| 1. If the diagnosis is unclear – e.g. a pregnancy of unknown location or of uncertain viability or a suspected molar pregnancy – explain the need for further assessment and acknowledge how difficult the period of uncertainty can be.
 |  |  |
| 1. If one or more babies in a multiple pregnancy dies but one or more is still viable, be sensitive to the feelings that the woman and partner may have. The continuing pregnancy or pregnancies may still be at risk and even if continuing, may be no compensation for the baby/babies that died.
 |  |  |
| 1. If the pregnancy is heterotopic – one ectopic and one intrauterine – and the intrauterine pregnancy is viable, be sensitive to the feelings that the woman and partner may have. Depending on how the ectopic is managed, the intrauterine pregnancy may still be at risk and even if continuing, may be no compensation for the baby that died.
 |  |  |
| 1. If you are giving the diagnosis of a molar pregnancy, ensure that you know whether the woman and partner are expecting this news (e.g. from a previous appointment, a letter or phone call). Be sensitive to the feelings they may have if they have already been coping with the diagnosis of miscarriage. Also be aware that molar pregnancy is uncommon and is a complicated diagnosis to understand.
 |  |  |
| 1. Give the woman and partner time to absorb the news, and answer as many questions as you are able to within your scope of practice.
 |  |  |
| 1. Reassure the woman and partner that sadly early pregnancy loss is not uncommon and it is very unlikely that the loss has been caused by anything they did or did not do.
 |  |  |
| 1. Give information about what happens next, provide written information, specific patient leaflets and a named contact with contact details - a template contact card is available from <http://www.nbcpscotland.org.uk/templates>
 |  |  |
| 1. Offer a copy of the scan picture if there is one and offer to keep a printed copy in the notes if they would prefer.
 |  |  |
| 1. Check that the woman and partner can get home or to the next appointment safely and, if not, help them to think about other options.
 |  |  |
| 1. It is not uncommon for women to pass their baby/pregnancy while on the toilet. Bedpans or similar should be provided in women’s toilets in A&E, early pregnancy, gynaecology and maternity settings.
 |  |  |
| 1. Consider NICE guidance NG126 for further information [www.nice.org.uk/guidance/ng126](http://www.nice.org.uk/guidance/ng126)
 |  |  |

B1. Next steps – first trimester miscarriage

See B2, B3, B4 for next steps for second trimester miscarriage, ectopic pregnancy and molar pregnancy. Please note that many principles are shared across all four kinds of loss.

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. All staff with whom a woman may be in contact about early pregnancy problems should acknowledge the anxiety she may feel and listen and communicate sensitively.
 |  |  |
| 1. Give clear information about what is happening and carefully discuss management options or recommendations – including risks – if appropriate.
 |  |  |
| 1. Provide written information and give time for decision making wherever possible.
 |  |  |
| 1. Discuss how the place of care – home or in hospital, early pregnancy, gynaecology or maternity ward – and geography may affect the management options available.
 |  |  |
| 1. Acknowledge any concerns the woman and her partner may have.
 |  |  |
| 1. Sensitively explain any reasons for a delay in further care – e.g. further scans, booking theatre time. Acknowledge that uncertainty and delays can be difficult. Provide written information and signpost online information where appropriate.
 |  |  |
| 1. In the Emergency Department, transfer a woman to the appropriate unit/ward as soon as possible or offer support to go home. Provide information about accessing and/or an appointment for further treatment or assessment.
 |  |  |
| 1. Provide clear information about possible pain and bleeding, and the possibility of miscarrying before the next appointment, and whom to contact if symptoms worsen before the next appointment.
 |  |  |
| 1. If the woman opts for expectant management or medical management at home, explain honestly what she might experience regarding pain and bleeding during and after the miscarriage. Remember to offer analgesics or advice on over-the-counter options and on the likely need for extra-absorbent sanitary pads.
 |  |  |
| 1. Acknowledge that waiting for the miscarriage to happen can be difficult and that the process itself may be distressing and provide details of whom she can contact if she needs support.
 |  |  |
| 1. In all cases, advise the woman sensitively that she may miscarry while on the toilet and offer information regarding pregnancy remains (see guidance for miscarriages that occur at home, available from [www.miscarriageassociation.org.uk/information/for-health-professionals/guidance-miscarriages-occur-home](http://www.miscarriageassociation.org.uk/information/for-health-professionals/guidance-miscarriages-occur-home)
 |  |  |
| 1. Inform the woman that she can usually change her mind about the management option and provide the appropriate contact details if she does.
 |  |  |
| 1. Ensure that all staff seeing the woman and partner during and after the process of miscarriage are aware of what is happening and communicate sensitively, using appropriate language and terminology.
 |  |  |
| 1. Aim for continuity of carer where possible.
 |  |  |
| 1. Ask if the woman or couple are wondering what they might see when she miscarries and be prepared to talk this through. Offer to tell the woman and partner what their miscarried pregnancy might look like - see the Miscarriage Association’s guidance on management of miscarriage [www.miscarriageassociation.org.uk/wp-content/uploads/2016/10/Management-of-miscarriage-2016.pdf](http://www.miscarriageassociation.org.uk/wp-content/uploads/2016/10/Management-of-miscarriage-2016.pdf)
 |  |  |
| 1. Ask the woman if she would like the pregnancy loss form completed to alert staff who provide further or future care - a template form is available from [www.nbcpscotland.org.uk/templates](http://www.nbcpscotland.org.uk/templates) or use another means to alert staff, e.g. a teardrop sticker or digital icon.
 |  |  |
| 1. Provide information about histology or post mortem examination if appropriate (see section D).
 |  |  |
| 1. Discuss the options for cremation and burial (see section D).
 |  |  |
| 1. Describe the help that support organisations can offer and provide contact details if the woman or her partner wishes to have these.
 |  |  |

B2. Next steps – second trimester miscarriage

In addition to the guidance on first trimester miscarriage in section B1 above

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Ensure that the woman is cared for in the appropriate care environment by staff who are sensitive to her needs.
 |  |  |
| 1. Discuss the arrangements, including where she will deliver and possible ways of marking the loss and/or making memories (see section C).
 |  |  |
| 1. Prepare the woman and partner for what to expect during labour and delivery, including information about pain relief and how long the process might take.
 |  |  |
| 1. Offer to tell the woman and partner what they might expect their baby to look like, depending on the gestation.
 |  |  |
| 1. Provide a named contact in case the woman changes her mind or has any questions.
 |  |  |
| 1. Ensure all staff seeing the woman and partner during labour and delivery are aware of the baby’s death and communicate sensitively.
 |  |  |
| 1. Women are likely to need additional emotional support during labour.
 |  |  |
| 1. Enable the woman to have a partner or support person with her at all times.
 |  |  |
| 1. With the woman’s consent, keep the partner or support person informed.
 |  |  |
| 1. Provide the partner or support person with emotional support.
 |  |  |

B3. Next steps: ectopic pregnancy

In addition to the guidance on first trimester miscarriage in section B1 above

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Give clear and understandable information (verbally and in writing where possible) about management options, risks, benefits and any recommendations, and allow time for discussion and decision making wherever possible.
 |  |  |
| 1. Be sensitive to the feelings the woman and partner may have about their loss, risks to the woman and implications for her fertility. Recognise that they may have already been coping with the diagnosis of miscarriage or pregnancy of unknown location.
 |  |  |
| 1. If the woman opts for expectant or medical management, explain the need for continued monitoring and further appointments, and advise on the potential need for treatment, further treatment or surgery in some cases. Provide a contact name and/or number so the woman and partner can ask questions or seek advice at any time.
 |  |  |
| 1. If surgical management is advised/opted for, clearly and sensitively explain the steps for hospital admission, pre-operative preparation and surgical routes including any recommendations (keyhole, open) and possible outcomes, e.g. for an affected Fallopian tube.
 |  |  |
| 1. Provide a contact name so that the woman and partner can ask questions or seek advice.
 |  |  |
| 1. Offer to tell the woman and partner what they might expect the remains of their baby or pregnancy to look like, depending on the gestation and the type of management used.
 |  |  |
| 1. Provide information about pain relief and physical and emotional care.
 |  |  |
| 1. Discuss the options for cremation and burial in the same way as you would following miscarriage (see section D).
 |  |  |

B4. Next steps – molar pregnancy

In addition to the guidance on first trimester miscarriage in section B1 above,

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Give clear and understandable information regarding the recommendation for surgical management if this is needed, recognising that this may be the woman’s second procedure.
 |  |  |
| 1. Give clear information about the follow up process, why it is needed and what it will involve.
 |  |  |
| 1. Provide contact details of the Scottish Hydatidiform Mole Follow Up Service at Ninewells Hospital, to which the woman will be referred, so the woman and partner can ask questions or seek advice at any time.
 |  |  |
| 1. Be sensitive to the feelings the woman and partner may have regarding their loss, the possible risks for the woman’s health and implications for future pregnancies. Provide information about organisations that can offer further support.
 |  |  |
| 1. Discuss the options for cremation and burial in the same way as you would following miscarriage (see section D).
 |  |  |

C. Marking the loss, making memories

In first or second trimester loss

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Recognise that some women and partners will choose to mark their loss or create memories in some way. Some will appreciate the offer of help to do this and others will not.
 |  |  |
| 1. Do not make assumptions about what she or they might want based on the gestation of their pregnancy but be aware that some options will not be possible with early loss.
 |  |  |
| 1. Allow time for making decisions and for the possibility of changing those decisions. This is especially important if a couple feel differently about marking loss and memories. Note that some options will be time-limited and make clear any time frame for making decisions. Respect the decision the woman and partner make.
 |  |  |
| 1. Depending on the condition of the baby or pregnancy remains, offer the woman and partner the opportunity to discuss
 |  |  |
| * 1. seeing and/or holding their baby or remains, in a suitable container if needed – local or national organisations may be able to supply appropriate resources, offer to describe the (likely) appearance of the baby or remains first
 |  |  |
| * 1. a memory box, or similar, appropriate to the gestation or items for a box if they prefer
 |  |  |
| * 1. a copy of the scan image, if one is available and it has not already been given to the woman
 |  |  |
| * 1. certificate of loss - a template certificate is available from [www.nbcpscotland.org.uk/templates](http://www.nbcpscotland.org.uk/templates)
 |  |  |
| * 1. [entry in a book of](http://www.nbcpathway.org.uk/) remembrance, if available
 |  |  |
| * 1. photographs of the baby or remains
 |  |  |
| * 1. hand and footprints, if the baby’s condition allows
 |  |  |
| * 1. other memories or mementos.
 |  |  |
| 1. Where there is a loss or death in a multiple pregnancy, consider discussing the options for marking the loss with surviving siblings.
 |  |  |
| 1. Consider offering information about other remembrance events within or outwith the hospital or healthcare setting.
 |  |  |
| 1. Complete the informed choice form to indicate that the woman and partner have been offered options, but without pressuring them - a template form, ‘Creating memories – offering choices’, is available from [www.nbcpscotland.org.uk/templates](http://www.nbcpscotland.org.uk/templates)
 |  |  |

D. After the loss

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| *Histology and post mortem* |
| 1. Remember to keep within the scope of your practice when providing information, explaining procedures or answering questions. Be prepared to consult with or refer to suitably trained colleagues whenever necessary.
 |  |  |
| 1. Ensure that all discussions take place in a quiet, private place.
 |  |  |
| 1. If histological examination of pregnancy remains or the placenta is recommended, ensure the woman and partner understand why and also the limitations of the examination.
 |  |  |
| 1. If seeking consent for histological examination, aim to do so when obtaining consent for surgical management.
 |  |  |
| 1. Ensure that the woman and partner understand ‘fetal karyotyping’ or other investigations if being offered.
 |  |  |
| 1. Offer to explain options for cremation and burial of pregnancy remains.
 |  |  |
| 1. Ensure staff discussing post mortem examination with the woman and partner are trained to do so and are fully aware of the protocol for offering a full or limited post and know how to complete the form.
 |  |  |
| 1. Allow sufficient time for discussing post mortem and gaining authorisation if appropriate.
 |  |  |
| 1. During the authorisation process, inform the woman and partner of the likely timescales for the return of their baby and how and when the results will be communicated and be as realistic as possible about these.
 |  |  |
| 1. Inform the woman and partner if the post mortem examination will take place at a different hospital and explain where and why.
 |  |  |
| 1. Explain that all transport arrangements and handling of the baby will be respectful and caring and who will be responsible for this Identify a named pathology or maternity contact who will be responsible for following up on the results.
 |  |  |
| 1. Make sure anatomical pathology technicians and/or pathologists are aware of any specific cultural or religious requirements or special requests from the family.
 |  |  |
| 1. Ensure any small objects or keepsakes such as a hat or cuddly toy that accompany the baby are returned following the investigation
 |  |  |
| 1. Provide information about cremation and burial (see section D).
 |  |  |
| *Certification* |
| 1. Offer to provide a ‘certificate of loss’ - a template certificate is available from [www.nbcpscotland.org.uk/templates](http://www.nbcpscotland.org.uk/templates)
 |  |  |
| 1. If the miscarriage occurred at home, refer to the guidance for miscarriages that occur at home [www.miscarriageassociation.org.uk/information/for-health-professionals/guidance-miscarriages-occur-home/](http://www.miscarriageassociation.org.uk/information/for-health-professionals/guidance-miscarriages-occur-home/)
 |  |  |
| 1. If a baby was born after 24 weeks’ gestation but it is known or can be proven that the baby died before 24 weeks, the death cannot be recorded or registered as a stillbirth.
 |  |  |
| *Cremation, burial and funerals* |
| 1. Advise that a minimum standard by a hospital for sensitive disposal of pregnancy loss under 24 weeks is shared cremation. Individual cremation or burial may also be considered. The individual may also make private arrangements outwith the hospital, including burial at home.
 |  |  |
| 1. Advise that signed authorisation is required before the hospital can sensitively dispose of the pregnancy loss.
 |  |  |
| 1. Provide the woman and partner with written information about these options, including information about the recovery of ashes, but recognise that some women and partners will not want to read or discuss it or to make a decision. In this situation they may authorise someone else to make the decision or authorise the hospital to arrange for shared cremation.
 |  |  |
| 1. If the woman and partner do not want the information, explain that they can get back in touch if they change their minds (and provide the time frame for doing so).
 |  |  |
| 1. Verbal and/or written information should include
 |
| * 1. choices they have if they want the hospital to make arrangements and the costs, if any
 |  |  |
| * 1. financial support payment available to families on low income via Social Security Scotland
 |  |  |
| * 1. choices they have if they want to manage the arrangements, including burial at home and information on local funeral directors if available
 |  |  |
| * 1. time frame for making and communicating that decision
 |  |  |
| * 1. hospital process if they do not make or communicate that decision within that time frame.
 |  |  |
| 1. Bear in mind and facilitate where possible different personal, religious and cultural needs and do not make assumptions.
 |  |  |
| 1. Discuss the options for urgent burial and cremation where appropriate.
 |  |  |
| 1. Inform the woman and partner about the chaplaincy team as a source of additional support or advice.
 |  |  |
| 1. Record all decisions made by the woman in her medical records, including where information is declined, or no decision is made.
 |  |  |
| See also Scottish government guidance on the sensitive disposal of pregnancy losses up to and including 23 weeks and 6 days gestation [www.sehd.scot.nhs.uk/cmo/CMO(2015)07.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO%282015%2907.pdf) and Miscarriage Association guide <https://www.miscarriageassociation.org.uk/wp-content/uploads/2020/08/Talking-about-sensitive-disposal-of-pregnancy-remains-Good-practice-guide.pdf> and RCN guidance on managing disposal of remains [www.rcn.org.uk/professional- development/publications/pub-007321](http://www.rcn.org.uk/professional-development/publications/pub-007321)  |  |  |

E. Before discharge

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Ensure the woman is told about the possibility or likelihood of continuing or increasing pain and bleeding, which she may find distressing, and when and how to contact a healthcare professional. Discuss lactation and milk suppression if appropriate.
 |  |  |
| 1. Provide information on continuing care/follow up for this pregnancy loss and, if known and appropriate, on the hospital’s policy for offering investigations into possible causes.
 |  |  |
| 1. Provide information, if appropriate, on the hospital’s policy for early scanning or testing in pregnancy after this loss.
 |  |  |
| 1. Discuss with the woman and partner the emotions they may experience, so they know that feelings of grief and loss are common and understandable, but so too is acceptance and in some cases, relief. Avoid the word ‘normal’ in case they don’t feel this way.
 |  |  |
| 1. Offer contact with the chaplaincy team.
 |  |  |
| 1. Promptly inform primary care staff and all relevant departments that the woman has experienced a miscarriage, ectopic or molar pregnancy, so that future associated appointments are cancelled.
 |  |  |
| 1. Offer to mark the woman’s notes to alert staff who provide further or future care, e.g. with a teardrop sticker or digital icon. If the loss was from a multiple pregnancy, offer to use the ‘Butterfly Sticker’, available from the Twins Trust, and ensure staff recognise this as identifying women and partners of a surviving baby who have suffered the loss of a baby/babies from a multiple pregnancy.
 |  |  |
| 1. Ask the partner if they would like their own GP to be informed and if so, take details and action this.
 |  |  |
| 1. Before the woman and partner leave the hospital, give them the contact details for primary care and secondary care staff and local and national support organisations.
 |  |  |
| 1. Advise all women and partners on how to request a follow up appointment with the unit (if available) and/or their GP. If you offer a follow up appointment, explain what to expect from it and if possible, book the appointment allowing sufficient time for the woman and partner to ask questions and talk about their experience.
 |  |  |
| 1. Offer referral to a recurrent miscarriage clinic if appropriate.
 |  |  |
| 1. Offer to cancel the Baby Box delivery if it has already been requested, and the woman, partner or a family member wishes. The box can be cancelled by calling 0800 030 8003. The call can be made either by the parent, a family member or a nominated health professional. However there is no need to cancel if they prefer to have the box.
 |  |  |
| 1. Consider NICE guidance QS115 on antenatal/postnatal mental health [www.nice.org.uk/guidance/qs115](http://www.nice.org.uk/guidance/qs115) and SIGN guidance on perinatal mood disorders <https://www.sign.ac.uk/our-guidelines/management-of-perinatal-mood-disorders/>
 |  |  |
| *Feedback* |
| 1. Discuss with the woman and partner how they can give feedback about the bereavement care they received.
 |  |  |
| 1. If the woman and partner give consent to be contacted for feedback, let them know how and when they will be contacted about this and document consent to participate.
 |  |  |
| 1. Let women and partners know they can give feedback to hospitals and other healthcare [services and share their stories via Care](http://www.londonscn.nhs.uk/wp-content/uploads/2017/06/mat-%20bereavement-mbem-062017.pdf) Opinion [www.careopinion.org.uk](http://www.careopinion.org.uk)
 |  |  |

F. Support in the community

|  | Y/N/P  | *Resources or support needed?* |
| --- | --- | --- |
| 1. Once notified of the loss the GP practice, primary midwives or health visitors should consider contacting the woman to acknowledge the loss and offer further contact if she wishes.
 |  |  |
| 1. The loss should be coded in the GP notes and references to an ongoing pregnancy cancelled.
 |  |  |
| 1. At follow up and subsequent appointments,
 |
| * 1. pay attention to the woman’s emotional wellbeing as well as physical needs
 |  |  |
| * 1. listen to the words the woman and partner use and take those words and their fertility history into consideration when responding
 |  |  |
| * 1. be ready to answer questions about potential future pregnancies and whether anything can be done to reduce risk
 |  |  |
| * 1. make sure women and partners know whom to contact if they would like preconception advice where appropriate.
 |  |  |
| 1. Ensure you are aware of the types of bereavement support available within the NHS and from support organisations and provide details.
 |  |  |
| 1. Offer referral for specialist psychological support if there are signs that might indicate PTSD or clinical depression.
 |  |  |
| 1. Consider NICE guidance QS115 on antenatal/postnatal mental health [www.nice.org.uk/guidance/qs115](http://www.nice.org.uk/guidance/qs115) and SIGN guidance on perinatal mood disorders <https://www.sign.ac.uk/our-guidelines/management-of-perinatal-mood-disorders/>
 |  |  |