Pregnancy loss research group
National Perinatal Epidemiology Centre

Maternity staff opinions on perinatal death reviews: focusing on parent involvement and changes to the system

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Background

- Perinatal death review programmes collect perinatal mortality data and identify modifiable or preventable factors in perinatal deaths.
- Perinatal death reviews in Irish maternity units are not standardised or transparent.
- Reviews may provide closure and answers to bereaved parents though many parents remain unaware of the review process and have little involvement.
- A standardised review tool for perinatal death reviews would help to ensure consistency in the review process, promoting a fair and equal review system for all bereaved parents across the country.
- This pre-implementation qualitative study aimed to explore the opinions of staff in Irish maternity units regarding the existing perinatal death review system, parent involvement in reviews and changing the review system to one that is standardised.

Methods

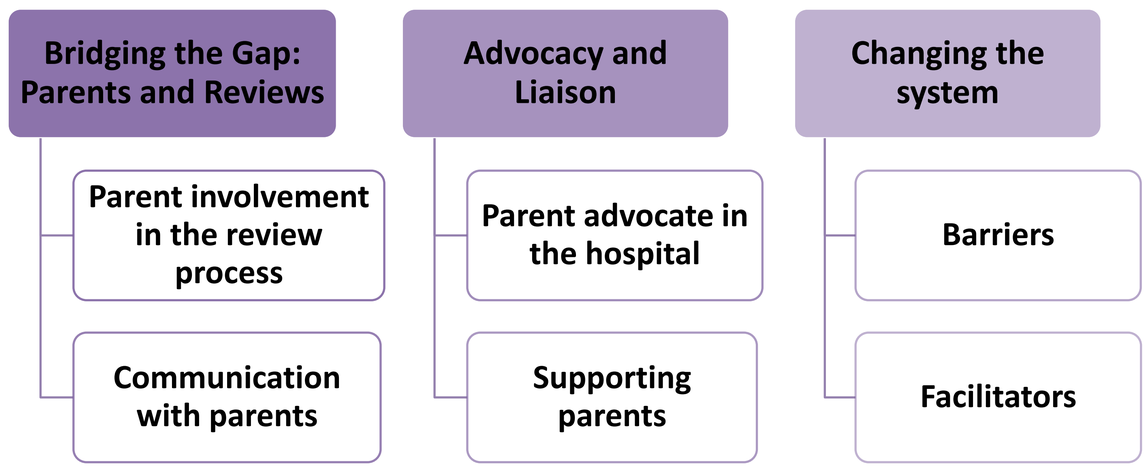
- One-on-one semi-structured interviews were conducted with staff working in the maternity services.
- Inclusion criteria:
  - A) Participants had to be over the age of 18
  - B) Fluent in English
  - C) Experience with either perinatal death or perinatal death reviews
- Purposeful and snowball sampling was used to recruit participants.
- A topic guide was used with questions on the existing process in the unit, changing the system to one that is standardised and parent involvement in reviews.
- Reflexive thematic analyses (Braun and Clarke) was applied.
- NVIVO 14 was used for data analysis.

Results

Table 1: Participant characteristics

	Interviews: • 32 interviews across 3 maternity hospitals/units • May to December 2022
	Participating maternity units: • Ranging in size from approx. 1,400 deliveries per year to approx. 6,800 deliveries per year • Located in different geographical regions • Different hospital groups/hospital infrastructure
	Participant professional background: • Medical background: obstetrics & gynaecology, neonatology consultants and doctors-in-training • Midwifery: staff midwives and management • Risk management/quality & patient safety • Patient liaison services • Pastoral care

Figure 1: Themes and subthemes



Theme: Bridging the Gap: Parents and Reviews
Subthemes:

- Parent involvement in the review process: participants in two units felt that parents were not involved enough in the existing review process.
- Communication with parents: participants emphasized the importance of adequate and ongoing communication with parents in the weeks and months following the death of their baby.

"I do think it would be great for parents (…), to be reassured that there is a standardised process that is being followed and they might also have a pamphlet or something with a diagram showing this is what, essentially, are the steps."

"I think [parents] have a really important voice as part of the review, (…) they can ask probing questions that we may not have thought of or addressed, I think it's really important to get them involved at the very beginning of the review…"

Theme: Advocacy and Liaison
Subthemes:

- Parent advocate in the hospital: the importance of a parent advocate who was independent from the review team to help parents navigate the review process was mentioned by participants in all units.
- Supporting parents: participants mentioned the support services available to bereaved parents in all units. They particularly emphasized the importance of the bereavement and loss midwife specialist.

"I like the idea of maybe having somebody like a patient liaison officer, something like that, who would be the advocate for the parents and help them and not just when there's a bad outcome but for complaints as well or for if they're looking to access care."

"I think the bereavement midwife is just pivotal in this and their relationship with these women can go on to six months, a year."

Theme: Changing the system
Subthemes:

- Barriers: resistance to change, Coroner-related delays and time challenges were the most frequently reported barriers to changing the system with the introduction of a standardised review tool.
- Facilitators: a tool that is user-friendly, easy to complete, available online, and providing training about using the tool were the most frequently mentioned facilitators for a standardized review tool.

"It's going to have to be much more concise and user friendly so that a first-time user would be able to access it and guide themselves through the tool without (…) supervision"

"That's very frustrating when you see no change or you see people who are resistant, not resistant to change but, you know, they themselves decide there is no change that's needed. Sometimes you're trying to convince people that there's a change needed is very difficult"

Conclusions

- The perinatal death review process was different in each unit.
- It is important to address the highlighted barriers to changing the system before a standardised review tool is implemented.
- Parent involvement in the review process needs to be considered by key stakeholders and strengthened in a standardised manner.
- Ongoing and clear communication with bereaved parents during the review process is paramount.

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