THE INITIAL care given to suddenly bereaved parents of infants can have a long-term influence on their grieving processes (Nussbaumer and Russell 2003, Knapp and Mulligan-Smith 2005). Good bereavement care is essential, therefore, but many emergency department (ED) staff struggle to provide this care because they find the reactions of suddenly bereaved parents so painful to witness (Dent and Stewart 2004).

Such care can be difficult to provide also because healthcare professionals and bereaved parents who have not had opportunities to develop deep relationships do not communicate well (Knapp and Mulligan-Smith 2005). High workload and time pressures in EDs can also prevent nursing staff from dedicating as much of their time as they would like to caring for bereaved parents (Bucaro et al 2005).

Senior, experienced nurses are usually best placed to support junior staff in caring for bereaved parents or to provide such care themselves (Hindmarch 2000).

But, if nurses are to remain with parents who have been suddenly bereaved, without interruption, adequate time and staffing must be allocated to this aspect of care (Levetown 2004, Foresman-Capuzzi 2007, McGearry 2008).

If low staffing levels make such allocation impossible, nurses should act as advocates for bereaved parents and ensure that they receive support from nurses working in children’s wards or baby care units, or from hospital bereavement or chaplaincy services. Chaplaincy services should be contacted only with the parents’ agreement although, regardless of staffing situations, all bereaved families should be asked if they want their religious leaders to be contacted (Nussbaumer and Russell 2003, Knapp and Mulligan-Smith 2005).

If staffing levels have compromised the care of bereaved parents, ED nurses should discuss this with senior staff, either during debriefing sessions or through incident-reporting systems, to ensure such situations do not recur.

Training and education
Bereavement training for ED staff is recommended in the Bristol Royal Infirmary inquiry final report (Kennedy 2001) and by the Foundation for the Study of Infant Deaths (FSID) (2005a), while several studies advocate the introduction of bereavement care programmes for ED staff (Williams et al 2000, Bucaro et al 2005, Mackenzie and MacCallam 2009).

Staff must understand the processes and legal requirements that follow sudden infant death (SID), not least because distraught parents often rely on them for guidance about what will happen next and what they should do (Dent and Stewart 2004).
Most ED nurses can show empathy and listen sympathetically to bereaved parents, and many have the non-verbal communicative skills and ability to deal with grief and anger that are required to deliver best practice in this area (McGeary 2008).

These skills and abilities are developed through professional and personal experience. They are combined with knowledge and understanding of the processes and legal requirements after SID to create bereavement care pathways. All SIDs are unique, so such pathways must be flexible enough to meet the varying needs of different parents.

Although some deaths have sinister causes, these are usually unknown at the time of ED care, and staff should remain open minded and committed to providing the highest level of care (Kennedy 2001) from the moment the parents and their babies enter the ED.

Best practice

Named nurses In each case of SID, parents should be allocated immediately named members of staff, usually nurses, who will remain with them throughout their time in the ED. These nurses should not be involved in resuscitation attempts but should stay with the parents and keep them informed and updated (Levetown 2004, Foresman-Capuzzi 2007, McGeary 2008).

These nurses should learn the names of all family members present and their relationships to the infant (Foresman-Capuzzi 2007), and should try to find out whether important family members, such as siblings, are absent and should be contacted (Child Bereavement Charity (CBC) 2007). They should also be aware of family arrangements, for example whether the bereaved parents are separated or have new partners (Dent and Stewart 2004).

When bereaved parents have been told that the infant has died, they and any other family members should be given time to express their feelings and ask questions (Williams et al 2000). Named nurses should sit with them, make eye contact and remain with them as much as possible (Kennedy 2001, Levetown 2004).

Infants should always be referred to by name (FSID 2005a, CBC 2007), medical jargon should be avoided and staff should be honest (Hindmarch 2000, Levetown 2004, Foresman-Capuzzi 2007).

According to the CBC (2007), ED staff should not think that they have to restrain their emotions; their distress can demonstrate their compassion. But they must retain their professionalism and become advocates for the parents (Foresman-Capuzzi 2007).

One of the most important aspects of caring for bereaved parents is the recognition that they remain parents and need to care for, love and protect their infants as if they were still alive (CBC 2007).

Such parents should be given time to hold and cuddle their infant and, where possible, be able to choose what they should wear (Dent and Stewart 2004, CBC 2007). They may also want to help wash and dress their infant if this is permitted by the local coroner.

Siblings Parents may ask staff for advice on responding to questions from the infant’s siblings.

The CBC (2007) suggests that children should be told about the death of a brother or sister by people they know and trust, preferably their parents, because this helps them to believe the bad news.

Seeing the deceased can also help them to validate what they have been told and allows them to say goodbye (Levetown 2004, CBC 2007). They may also want to help wash and dress their infant if this is permitted by the local coroner.

Parents should be advised that children’s reactions to death vary according to their ages (Dent and Stewart 2004), and that they grieve differently from adults.
Offering detailed advice on how to help bereaved children is likely to be beyond the remit of many ED nurses, but basic advice coupled with supporting literature and information about bereavement groups should be provided to parents. Leaflets designed specifically for children are available from organisations such as the CBC and these can also be given to parents to help their other children make sense of their grief.

Mementoes Parents can be offered mementoes of their infants (Levetown 2004, FSID 2005a, CBC 2007, McGearry 2008) such as locks of hair, photographs or impressions of their hands or feet. These can be of great value to parents because they provide tangible aids to remembering their infant (CBC 2007).

In such cases, staff must ensure that the taking of mementoes is permitted by the coroners concerned (FSID 2005a) who have jurisdiction over the infant’s body once death is declared. To clarify the procedures that the coroner wants followed, staff can check local policies (Buraco et al 2005, FSID 2005a).

To ensure that nurses’ actions are recorded accurately, nurses must document clearly in patients’ notes what mementoes were taken and given to parents. Nurses must also note that parental consent was obtained for taking them (Foresman-Capuzzi 2007).

If parents do not at first want mementoes, these can be stored with the infant’s clinical notes in case the parents change their mind (Osborne 2000).

Written information Suddenly bereaved parents experience such shock and distress that they are unlikely to be able to retain all the information they are given in the ED, so it is important to provide written information that includes contact numbers (Royal College of Paediatrics and Child Health 2007, McGearry 2008). The CBC, DH and FSID provide a range of leaflets that cover all the pertinent information.

It is important to reassure these parents that their infant will continue to be cared for after they leave the ED, and it may help them to know who will be caring for their baby and where they will be (Hindmarch 2000, CBC 2007).

Giving the names and contact numbers of mortuary staff can personalise the continued care giving and reduce parental anxiety.

Rapid response team All SIDs require multiagency responses (FSID 2005b) and the Bristol Royal Infirmary inquiry final report (Kennedy 2001) recommends that, immediately after apparent SIDs, a rapid response team (RRT) should be called. These teams usually comprise a social worker or health visitor, a lead paediatric consultant with a special interest in SID and a police officer from the local child safety team (FSID 2005b).

These RRTs enquire into and evaluate the causes of death immediately after they have occurred, and the information they gather is reviewed by child death overview panels to establish why the infants have died and whether their deaths could have been prevented (RCPCH 2008).

To start each inquiry, RRT members attend the relevant EDs, so bereaved parents should be made aware that they will be required to meet a range of professionals, including the police, and that, within the next 24 hours, they will be visited in their homes by RRT members (FSID 2005a, RCPCH 2008).

It is important to reassure the parents that these meetings and visits are standard procedures to evaluate the circumstances of the infant’s death as fully as possible (RCPCH 2008).

Bereaved parents should also be informed that information obtained by all healthcare professionals will be shared with the police and other agencies as part of evaluations and that, therefore, these healthcare professionals are not bound by the usual rules of patient confidentiality (RCPCH 2008).

Aftercare Care after SIDs does not stop when the bereaved parents have left the ED. Emergency care staff can have a role to play in this ongoing care even though it is given mainly by primary care professionals.

It is their responsibility, for example, to ensure that all the relevant professionals, such as the infant’s GP, health visitor and social worker, are notified (FSID 2005a) of the death so that ongoing care of the family can be delivered.

Emergency care staff should consider whether the infant’s mother requires lactation suppression and whether the infant was one of a multiple birth, in which case the surviving infant or infants will need hospital admission for full assessment (FSID 2005a). Staff should also consider whether school nurses should be contacted to ensure support for the deceased infant’s siblings when they return to school.

Finally, some authors suggest that bereaved parents can benefit from receiving condolence cards from ED staff (Bucaro et al 2005, Knapp and Mulligan-Smith 2005) to demonstrate their support and to help parents return to the ED if necessary.

Staff debriefing Aftercare is also required by the staff involved. Providing bereavement care, particularly after SIDs, is emotionally demanding and stressful, and staff should be given time to...
reflect on their experiences, resuming their duties only when they feel able to.

They should not be expected to resume other duties immediately but may benefit from working in other areas of the ED for the remainder of their shifts so that they are not involved in other resuscitations (Levetown 2004).

Defusion and critical incident stress deb briefings (CISDs) are useful methods of group reflection that can offer staff opportunities to discuss events and how they feel about them (Josland 2008, McGeary 2008).

Of these methods, defusion involves talking informally after events have occurred but before staff have ended their shifts to allow immediate feelings and thoughts to be expressed (Josland 2008).

The more formal and structured CISDs, meanwhile, are usually undertaken within between 24 and 72 hours of events having occurred and are open to everyone involved in them, not simply ED staff (Josland 2008).

Many nurses find debriefing a valuable exercise that helps them to understand their feelings after failed paediatric resuscitations (Ireland et al 2008).

Without debriefing, the staff involved in bereavement care may fail to realise that they have been affected (Gamble 2001) and are at high risk of developing emotional detachment, increased stress, burnout and even post-traumatic stress disorders (Knapp and Mulligan-Smith 2005).

Providing best-practice bereavement care after SIDs is crucial to the long-term grieving process of parents but can be difficult for staff due to their feelings of helplessness, inadequate training and their lack of existing relationships with parents.

These problems can be overcome, however, if staff are provided with the knowledge, skills and specific guidance on bereavement care.

All EDs should have bereavement guidelines so that some form of support and advice can be accessed by staff at point of care (RCPCH 2007), and these guidelines should describe the needs of parents, how staff can help to meet these needs and how to provide the best possible care in EDs.

Staff should also be aware that, although ED nurses are the constant care providers after SIDs have occurred, a multiagency approach involving a range of health and social care professionals is often required.

Nurses should use their communication skills and show empathy. These skills should be complemented by knowledge of the legal requirements and other aspects of care, including parental choice, mementoes and aftercare of both infants and their parents.

### Implications for practice

Caring for bereaved families is one of the most difficult aspects of emergency nursing yet delivering it effectively can be rewarding. This can only be achieved, however, by providing emergency department nurses with the appropriate skills, training and support. See Noticeboard, page 10.

### Further reading


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**References**


Child Bereavement Charity (2007) Best Practice Guidance for the Care of a Family: When their Baby or Child Dies in the Neonatal, Paediatric or Accident and Emergency Unit. Child Bereavement Charity, High Wycombe.


