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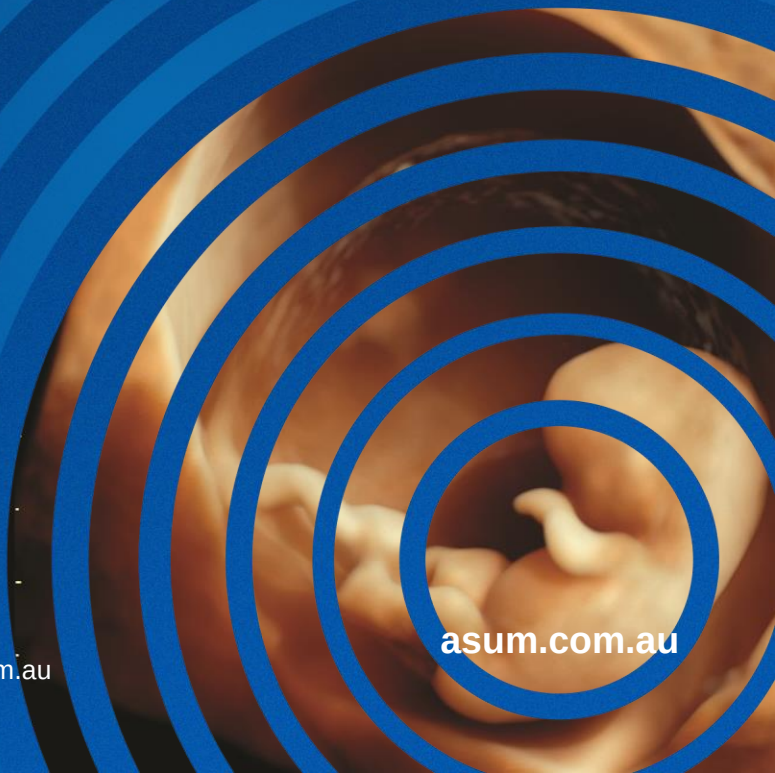
Promoting ultrasound excellence

Parent-centred communication in obstetric ultrasound

ASUM Guidelines



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1. Definitions and Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ASAR	Australian Sonographers Accreditation Registry
ASUM	Australasian Society for Ultrasound in Medicine
EPAS	Early Pregnancy Assessment Service
hCG	Human Chorionic Gonadotropin is a hormone that may be measured to test for pregnancy
MRTB	Medical Radiation Technologist Board (New Zealand)
OCUG	Obstetrics Communication in Ultrasound Group
Interim Report	A provisional/preliminary/interim indication of diagnosis/findings following the ultrasound examination. However, this does not constitute a report but provides the parent and managing clinician with important information to support clinical outcomes.
Parent(s)	For the purposes of this document, a “parent” or “parents” constitutes the pregnant person and the partner.
Parent-centred care	The delivery of comprehensive care that recognises, respects and incorporates the parent’s needs, values, culture and preferences.
Partner	Includes father, mother, husband, wife, parent, significant other, boyfriend, girlfriend, surrogate, guardian.
PSANZ	Perinatal Society of Australia and New Zealand
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCR	Royal Australian and New Zealand College of Radiologists
Referring clinician	The clinician who has initiated the ultrasound examination, typically includes obstetrician, independent midwife, general practitioner.
Report	A report represents the culmination of the process of interpreting the ultrasound study (or detailing what happened during an intervention). It is a formal document, medicolegally important, committing the reporting sonologist to an official interpretation of a single examination or procedure.
SCORE	Set up; Compassion; Open Communication; Respect; Everyone is Important (Acronym to support communication goals as described in section 3.2.1)

Sonographer	A health professional who has completed an accredited sonography qualification and continues to maintain clinical skills and continuing professional development appropriate for diagnostic ultrasound.
Sonologist	Reporting clinician. A medical specialist who reports on diagnostic ultrasound examinations. The use of sonologist in this document refers to a Clinical Radiologist, Obstetrician, or other medical practitioner with appropriate qualifications in diagnostic ultrasound.
Support person	A person who is attending the ultrasound examination along with the parent(s), including family members, extended family members, whanau, friend(s).
TOP	Termination of Pregnancy
Ultrasound Practitioner	Any ultrasound professional who performs or reports an ultrasound examination. At times, may refer to sonographer or sonologist in these guidelines.
WHO	World Health Organisation

2. Executive Summary

Patient expectations, set outside the healthcare sector, contribute to expectant parents anticipating a joyful obstetric ultrasound experience and confirmation of a 'healthy baby'. News of an unexpected or adverse event during that examination is rarely anticipated and may be devastating. Research indicates the expectant parents' preference is to hear unexpected news from their sonographer. Delivering obstetric news can be challenging. It needs to be communicated with compassion and sensitivity, by a practitioner who is appropriately trained and has the support of their workplace through overarching, inter-professional policy setting.

Currently, in Australia and New Zealand, a multitude of disparate practices for communicating obstetric news exists across radiology and obstetric services, both in urban and rural settings. Inconsistency in communication practices is due to current policy, or ultrasound practitioners feeling compelled to deliver obstetric news contrary to policy as they believe it is their moral duty (18). This inconsistency can result in the parent(s) leaving the ultrasound examination unaware of devastating news they need to consider.

The Australasian Society for Ultrasound in Medicine (ASUM) has identified an opportunity to improve care and support the profession by developing guidelines for the delivery of obstetric news, specific to the Australian and New Zealand environment. These guidelines will benefit sonographers, practice managers, radiologists, obstetricians, other ultrasound specialists and expectant parents by providing a consistent approach, utilising a best practice framework to enhance the delivery of obstetric news in line with current community expectations.

The ASUM Obstetrics Communication in Ultrasound Group (OCUG) is a multidisciplinary team that has embraced a collaborative approach to produce these guidelines, drawing on extensive local and international research, and liaising with relevant colleagues and peak bodies. To ensure these Guidelines become widely adopted, endorsement is being gathered from multiple organisations. These include groups who provide care and support for parents throughout and following their pregnancy and relevant professional bodies within the obstetric imaging sector. This will result in a robust framework that can utilise ongoing research and feedback to improve and adapt over time.

These Guidelines for Parent-Centred Communication in Obstetrics are our first step. They provide a pragmatic framework for ultrasound practices, professional bodies and educational institutions when delivering news of unexpected or adverse outcomes. In addition, the recommendations seek to support sonographers and educators by outlining specific phrases and parent-centred communication strategies they can apply, as research indicates this level of specificity is important to expectant parents (20,28,29,33)

As a collective obstetric ultrasound profession, we have an opportunity to start a new conversation, improve our workplaces and support expectant parents during their moment of critical need. Please embrace these guidelines and share them with your colleagues.

3. Part One – Guideline Aims and Development

3.1 Introduction

These guidelines are divided into two parts. Part One discusses the aims and considerations of the Obstetric Communication in Ultrasound Group in developing the guidelines. It addresses the need for parent-centred care, including the importance of ensuring all departments have protocols in place to support this goal.

3.2 Obstetric Communication in Ultrasound Group (OCUG)

Communication is the key to effective healthcare, although it is often overlooked with regards to training, roles and responsibilities, and transparency. ASUM has brought together a diverse interdisciplinary group from across Australia and New Zealand which comprises people with a range of lived experiences, sonographers, psychologists, radiologists, obstetric sonologists, educators, professional body representatives, and advocates. The aim of the group is to develop guidance for improved parent-centred care. Unexpected findings experienced by parents with lived experience include, but are not limited to, fetal anomalies and fetal demise.

These guidelines have been developed to improve the communication between parents and ultrasound professionals in the event of unexpected or ambiguous fetal or maternal findings. They incorporate consideration of ultrasound practice design to enhance a caring environment for parents and development of protocols to manage timely communication of results to the referrer.

3.2.1 Background

Dedicated education and training in both the performance and interpretation of the ultrasound examination are required to ensure maximum clinical benefit (1, 2). Technological advances have improved the image quality and therefore the diagnostic capabilities of the modality for all ultrasound practitioners. Consequently, there are now higher expectations regarding the ability of frontline ultrasound practitioners, predominantly sonographers, to diagnose unexpected findings whilst viewing the images concurrently with the parents. In addition to technical skills, effective practice requires non-technical skills, which refer to the cognitive, social, and personal aspects of care, and include the domains of communication and teamwork.

WHO guidelines and ACSQHC recommendations stipulate that there should be a person-centred approach to empower parents through the control of their own healthcare needs (3-5). Moreover, PSANZ and RANZCOG emphasise that the delivery of parent-centred obstetric ultrasound services, along with all maternity care, requires a collaborative, interdisciplinary approach (6, 7). Obstetric parent satisfaction and outcomes are influenced by the level of parent-centred care (8, 9). Parental bonding and understanding of ultrasound features have been enhanced with improved resolution and other techniques, including 3D and 4D ultrasound (10-12).

Parent-centred care includes good communication by healthcare professionals in all clinical settings. In an obstetric ultrasound setting in Australia and New Zealand, most ultrasound examinations are undertaken by sonographers and as such, they are the frontline practitioner communicating with pregnant parents and their support people. However, currently there is no standardised approach on whether to discuss unexpected findings with pregnant parents (13-15), nor is there compulsory training in how the diagnostic team should communicate these unexpected results. Studies have found this is both stressful and frustrating for sonographers who often feel they are not supported in these situations, particularly in

radiology practices (16). This can lead to sonographer burnout and long-term psychological trauma (17-19).

Pregnant women in Australia are usually scanned more than twice during pregnancy. Australian data indicates that approximately 20-25% of pregnancies result in an early loss (20-22) and fetal abnormalities and anomalies comprise 3% of pregnancies (23). Additionally, fetal growth restriction, placental, cord, and amniotic fluid disorders are common findings. These discoveries may result in parents experiencing psychological trauma and long term negative impacts (24, 25) which may be compounded if there is indifference and a perceived lack of care by obstetric health care professionals (26-33).

ASUM recognises that practicing obstetric ultrasound is technically and emotionally challenging for the ultrasound professionals, particularly in the assessment of possible maternal or fetal unexpected findings. This is due to the highly complex psychomotor skills and knowledge needed to identify potential abnormalities (34, 35). With the responsibility for detecting these unexpected outcomes comes the pressure on sonographers to interpret these anomalies in the company of the parents and often in the company of other support people, increasing the emotional stress of their professional role.

Departmental policies and protocols that do not reflect a parent-centred care model or align with current parent expectations of open communication inadvertently restrict a sonographer's professional role and may increase a sonographer's stress.

The goal of OCUG is to provide guidelines which support all healthcare professionals to provide optimum parent-centred care in obstetric ultrasound, particularly in the event of communicating an unexpected finding. This has been achieved successfully in the United Kingdom with consensus guidelines (36).

OCUG encourages a team approach with both the sonographer and reporting sonologist supporting each other by having a predetermined policy and protocol which integrates training in how to communicate findings directly to parents and ensure follow up care and communication with the referring clinician responsible for the mother's care.

3.2.2 Importance of parent-centred communication

Research has shown that the way in which parents receive news about adverse or unexpected findings may have implications for immediate and longer-term psychological wellbeing (37). Poor communication, including delays in receiving information, can also engender mistrust in the health system and undermine the relationship between parent and health care provider. Good communication is central to respectful and supportive care following the death of a baby, and begins at the first signs of concern about a pregnancy (38).

3.3 OCUG Five Overarching Goals

OCUG recognises that the care provided by ultrasound practitioners is inextricably related to organisational policies, guidelines, and training, and as such have developed five overarching goals with each recommendation and action contributing to parent-centered care in obstetric ultrasound.

Principles of Parent-centered communication in an Obstetric ultrasound setting are set out below as the 5 overarching goals to achieve it.

3.3.1 SCORE (Set Up; Compassion; Open Communication; Respect; Everyone is Important)

Set up	Compassion	Open communication	Respect	Everyone is important
Pre scan preparedness 1. Staff equipped with possible phrases/words for different potential situations. 2. Offer an interpreter if required. 3. Parent(s) supplied with a document for what to expect. 4. Before commencement of scan: • Introduce yourself and explain your role to build rapport with parent/s • Take a clinical history, including previous loss • Describe the purpose of the examination • Explain the examination process (e.g. I will be doing your examination, but it is standard practice that it will be reviewed by XXXX who is responsible for…) • Establish open communication • Listen/reply to any concerns from parents • Ask parents if they have understood everything, if they have any questions/concerns	• Timing of the news given is crucial • Empathetic explanation of concerns about unexpected findings • Show empathy, kindness, and genuine care for the impact of these findings on the parent/s. • Use words/terminology that are sensitive and appropriate to parent/s context (avoid using clinical language as appropriate)	• Be informed of your agreed, formalised department protocol • Use clear unambiguous explanations of the findings • If unsure of what the findings mean, explain that you are uncertain and offer to seek further clarification • Take care with your non-verbal communication, e.g. facial expressions or body movements, be physically at the same eye-level of the parent • Provide the parent with written information on what has been verbally communicated • Ensure the parent comprehends • Be honest; this maintains trust • Avoid evasive answers • Listen to verbal and non-verbal cues from the parent/s and acknowledge their responses	• Acknowledge the parent's feelings • Provide validation by acknowledging the parent's loss (e.g. by referring to the baby, and their parenthood – avoid using terminology such as 'fetus' or 'it') • Ensure that suitable uninterrupted time is taken after unexpected news is given • Find a quiet space for the parent to grieve before parent leaves the department • Show cultural and religious awareness • Avoid language or non-verbal communication that suggests judgement of the parent/s' reaction to unexpected news • Provide privacy but remain contactable • Always promote respect within the healthcare team	• Use a teams-based approach to supporting the parent/s and healthcare team • Provide emotional and social support for parent/s, family, sonographer, sonologist • Follow up with healthcare provider, taking into account the urgency of report, and urgency of parent follow-up appointment • Provide support resources to parent/s and healthcare team • Ensure accountability and a clear audit trail

3.3.2 Recommendations in the Case of Unexpected Findings

ASUM strongly encourages team-based practice with departmental policies to ensure parent-centred communication between a sonologist, sonographer, and parent.

Each practice or department should assess and determine the appropriate level of information communicated by each ultrasound practitioner. This approved level of communication should be dependent on their level of expertise as assessed by senior sonographers in consultation with the senior or managing doctor. Furthermore, if a junior ultrasound practitioner does not have the skill level required for a full, unambiguous explanation of the findings, then the reporting sonologist or senior sonographer must directly communicate with the parent either face to face or via phone before the parent leaves the department. However, this should be used as a learning opportunity for the junior ultrasound practitioner to upskill within a supportive educational framework.

Following explanation of the concerning finding to the parent, the referrer must be immediately contacted with the interim report, and a final report sent through as soon as possible.

When developing departmental policies and protocols the following elements should be considered:

- It is not within the scope of sonographers to discuss the clinical management following the scan and therefore caution is encouraged on the level of discussion with the parents to avoid any information that may not be in line with the opinion of the sonologist or referrer, or otherwise be misinterpreted and be the centre of discordance of parental advice.
- It is the responsibility of the clinical sonologist to instigate discussion and clinical management if the referrer is not available.
- The professional supervision protocols include flags for mandatory sonologist image review, ideally within 15 minutes of image production (either remotely or on site) and prior to the parent leaving the site.
- Authorising open and honest communication of unexpected and/or other relevant findings to a parent upon their request, by a sonographer on behalf of the sonologist and, if necessary, depending on communications options available, to the referrer.
- Practice protocols set out criteria for ultrasound practitioners discussion with parents (particularly obstetric parents) of unexpected findings when so requested by the parent. This should include open and honest communication with immediate provision of emotional and social support, subsequently to trigger immediate sonologist notification with subsequent annotation of the worksheet.
- The practice has protocols in place to provide ongoing professional support to sonographers and sonologists involved in such incidents.

3.3.3 Reporting and Sonologist Recommendations

ASUM, in line with RANZCR (39) and RANZCOG policy (6) states that for urgent significant unexpected findings, the reporting sonologist uses all reasonable attempts to communicate directly with the referrer or an appropriate representative who will be providing clinical follow up, makes a record of such actual or attempted direct communication, and co-ordinates appropriate care for the parent if they are unable to communicate such findings to the referring clinician.

The interim report is generally a personal or telephone conversation with the referring clinician by the sonologist or sonographer. Interim clinical information may also be conveyed as a copy

of the sonographer's worksheet/statement of findings, particularly for afterhours and geographically remote examinations

The sonographer worksheet/statement of findings is to document, in addition to the usual clinical history and ultrasound findings, all communication which has been discussed with the parent (partner/support person), including any follow up with the referring clinician and/or other healthcare providers involved in the mother's care, if known.

> Example: *"The parent was informed about the findings of the examination by xxxxxx. The sonologist and referrer were contacted and arrangements have been made for the mother to attend xxxxx(who and when). An urgent interim report has been arranged."*

The final report will, in addition to documenting the formal clinical findings and diagnosis, indicate the level of detail communicated to the parent or representative, and communication with the referring clinician or others, by and with whom, including the time and date and, if such was necessary, record any clinical arrangement made by the sonologist.

> Example: *"The parent was informed about the findings of the examination. They were told XXXX. They have been advised that a report will be issued immediately and that their referrer has been contacted on xx/xx/xxxx."*

OCUG encourages a clear audit trail to avoid any misrepresentation of the parent-healthcare professional encounter and ensure transparency. These actions will avoid any dispute or misunderstanding while also offering an opportunity for feedback and learning.

Professional supervision and its indicators thereof are relevant to adapting to parent-centred care in obstetric ultrasound.

A team-based approach works best in clinical radiology, as it ensures that those who provide service to parents do so efficiently, safely, and to the ultimate advantage of the parent.

3.3.4 Worksheets/Statement of findings and Sonographer requirements

The sonographer's interim report or worksheet is primarily a communication medium between the sonographer and the sonologist, and will contain communication data with the parent, the sonologist and referrer (if necessary), including time, person communicated with, and the relevant history and clinical information that contributes to the final report produced by the sonologist.

The interim report or worksheet may have a checklist of documentation which includes:

1. Who was present at the time of delivering the findings?
2. Distress levels of the parent/support person.
3. Degree of understanding of findings by the parent/support person.
4. Has the reporting doctor been notified?
5. Has the referring doctor been notified?
6. What is the parent to do next? i.e., go to Emergency Pregnancy Assessment Service (EPAS), go home, go to referring doctors' surgery, referring doctor to ring parent, tertiary referral to be organised and by whom?
7. Where are images and report to go to? Does the parent have a copy?

3.3.5 Ultrasound Examinations in Remote Locations, Weekends and On-call

It is recognised that clinical supervision of ultrasound examinations in remote locations will be conducted via different methods depending on the examination setting and the experience of the sonographer conducting the examination. It is important that sonographers are supported clinically in these remote settings, and particularly, that student sonographers are supported by both their sonographer peers and the reporting sonologist.

4 Part Two - Parent-Centred Communication

4.1 Introduction

Part Two provides a guide on how to achieve these goals, combining a collaborative teams-based approach with communication methods designed to support both the parent and the health professionals involved in their care.

4.2 Communication and Terminology

Many issues arise due to poor communication at the beginning of the examination.

Therefore, take time to present an overview and the expectations of the scan to eliminate a parent's anxiety about the unknown (40) which should also involve soliciting and gaining understanding of the parent's expectations and how they are feeling about the pregnancy.

4.2.1 Set-up

Pre-scan preparation by documentation sent out before the scan or on arrival at the ultrasound practice can allay many anxieties. Appendix A contains an example of a parent-facing document which could be given to parents prior to the ultrasound examination to prepare them for the scan and understand the process.

It is important to "set up" the ultrasound examination with introductions and a clinical history along with previous testing. The ultrasound practitioner should try to make the parent(s) and/or support persons comfortable and establish a trusting professional relationship by showing genuine interest in them, i.e., listening carefully and responding fully and in plain language to any questions asked.

To reduce parent anxiety, it is recommended prior to beginning the examination the sonographer advise the parent that in some cases it is necessary for a sonologist to also be present in the room at the time of scanning to assist in completing the examination.

Obtain a relevant clinical history including confirmation of dates prior to beginning the examination (important not to ask during the examination if a problem is detected)

For dating or viability scans the following questions may be asked:

> *"I need to ask you some more clinical questions now."*
>
> *"Have you been bleeding?"*
>
> *"Have you had any pain?"*
>
> *"When was your positive pregnancy test?" followed by "Was it a blood test or a urine test?" and "Do you know the hCG levels?"*

"How have you been feeling?"

"Have you had a previous caesarean section?"

In the case of a morphology or well-being scan, opening questions may include:

"Have you experienced any problems during the pregnancy?"

"Do you have any concerns regarding this pregnancy?"

Help prepare parents by explaining what they might expect to see (or not) for their particular gestation before beginning each scan. It is recommended that parents are advised there may be periods of silence during the ultrasound examination where the ultrasound practitioner will need to concentrate so that the best possible examination can be performed. Noting that once the ultrasound practitioner has completed aspects of the examination, dialogue will be continued with the parent/s. Be aware that parents may be highly attuned to verbal and non-verbal cues, such as sudden silence or an anxious tone.

The ultrasound practitioner should never assume the intended purpose of the ultrasound examination. For example, the parent may be planning a TOP and may not want to look at the screen, discuss results, hear a heartbeat, or engage in a detailed scan or questioning.

To overcome these complexities the ultrasound practitioner can ask questions which may indirectly give insight into the situation if they are not forthcoming, such as:

"How are you feeling about the pregnancy?"

"I am happy to show you the images on the screen, but if you prefer, I can turn the screen away. It's up to you."

"The ultrasound scan shows a live pregnancy, would you like me to give you more information?"

"The scan shows a pregnancy with a heartbeat, I haven't found anything concerning in your uterus or ovaries. Is there anything you wanted to know or see?"

There will be times when the parent attends the ultrasound examination alone and it is important during the set-up to understand if their partner or support person is available, should there be unexpected findings. The possibility of "virtual" attendance via phone when a support person is not physically present may be an acceptable substitution if practice protocols allow. Some phrasing may include:

"Are you expecting or waiting for a support person?"

"Is your partner parking the car?"

"I can notify reception to keep an eye out for your partner/support person and bring them in."

Where possible it is important to fully capture the images required for a clinical diagnosis before discussing unexpected findings with the parents, as it may be inappropriate to acquire additional images depending on the parents' emotional reaction.

Pause practical scanning while delivering unexpected findings and make eye contact whilst sitting at the same level during discussions. Use the parents' names (41, 42) as this will improve the rapport between the ultrasound practitioner and the parents, particularly during this difficult experience. Always be honest and avoid ambiguity or medical terminology that is not understood by a lay person, as you will immediately lose a parent's trust if they feel you are avoiding the truth or holding back information. Even if the situation is uncertain, it is important to provide assurance that all possible is being done and that information will be given as soon as it is available.

Practical examples of 'lead-in' statements for the ultrasound practitioner to start conversations regarding unexpected and adverse findings, specific to the gestation and type of outcome, are provided in Appendix B.

4.2.2 Terminology Considerations

It is acknowledged that every situation must be assessed individually, with respect to variations in parents' personalities, clinical history, and sonographic results. Active listening will help to gauge the parent's ability to understand the explanation, and the wording must be carefully selected to avoid any distress and misinterpretation of the findings. Clear, unambiguous terms should be verbalised and, in some situations written down, to assist in the explanation.

Careful consideration of the terms used in these discussions is important to avoid unintended psychological trauma. Special care should be taken to avoid negative, value-laden and stigmatising language to prevent unnecessary exacerbation of shock and distress as such language can influence the meaning parents make of unexpected news and inappropriately influence their decisions regarding the management of their pregnancy.

Practical guidance on terms to use and those to avoid are outlined in Appendix C, as a guide only, but ultrasound practitioners are encouraged to adapt to each individual situation to ensure parents are satisfied they understand the findings.

If a parent did not take up the offer of an interpreter at the beginning of the examination, consider offering one again prior to beginning any explanation.

Ambiguous explanations on areas beyond the clinical scope of the ultrasound practitioner should be avoided.

4.2.3 Parent Questions

Questions parents might ask following the news and possible answers:

Question	**Possible answer**
Are you sure?	*This is my interpretation from the ultrasound examination. I will contact your doctor and advise you on the next steps.*
What do I do now?	*I will come back shortly and tell you what to do next, but we're also going to contact your doctor. They will advise you on the next steps.*

Does this mean I have to have a procedure? How does the pregnancy/baby pass?	*Your doctor will talk to you about the options so that you can decide about what is best for you and your family.*
Will I have bleeding? Will I have pain?	*This varies between people, but you will get the care/support you need.*
Is this something I made happen? *Could I have prevented this?*	*This is not your fault. It's nothing that you did, and it's nothing that you didn't do. I'm so sorry this has happened to you. Your doctor will be able to provide you with more details*
Was it something I did?	*It's almost impossible to cause a miscarriage...*

4.3 Supportive Setting

When findings are communicated, there should ideally be a quiet area away from the busy waiting room for parents to absorb the information and not be forced to leave the department immediately, unless they so wish. In cases where the mother is attending the ultrasound examination alone, consider including a partner or support person when delivering difficult news and contacting that person by phone or other digital resources to help with ongoing immediate parent support. It is important not to leave parents alone (unless they wish) without a clear indication of their next steps.

It is recommended that parents receive clear, written information that has been verbalised about forward plans or arrangements as many parents report remembering very little of what was said to them during the scan due to the impact of shock.

When leaving the practice, it is preferable, where practical, for parents to exit via an alternative route to the main reception area. This may help to avoid perceived scrutiny from others while they come to terms with the findings of their ultrasound.

4.4 Training

Training in parent-centred communication is important for all members of the healthcare team, including receptionists, sonographers, and reporting doctors, to provide a supportive environment for the parent and her support people. The responsibility lies with each department to provide employees with access to training in this area and to maintain an audit trail of communication.

ASUM will be developing training and courses to support education in this essential area.

ASUM encourages universities to develop a compulsory unit addressing communication of findings directly with parents as a priority. OCUG recommends that accrediting bodies consider applying a compulsory education component in communicating findings as part of their certification process.

OCUG will help instigate a support group for ASUM members who are struggling with the emotional labour of their obstetric work and recommend that professional organisations and employers develop supportive programs to recognise and alleviate mental health issues amongst their staff members.

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Appendix A – Parent-facing document

Today's ultrasound

Eager anticipation, excitement, mild trepidation, nervousness – these are common pre-scan emotions experienced by almost everyone. Your sonographer is here to guide you through this experience.

Your sonographer will perform the ultrasound examination and the radiologist/obstetrician will provide the final report to your doctor.

Please let your sonographer know if you would like an interpreter for your examination.

What can you expect from your ultrasound experience today?

Before the ultrasound exam begins, your sonographer will explain what will happen throughout the overall process and what you are likely to see on the ultrasound at your expected stage of pregnancy.

Some ultrasound exams take longer than others to study and to capture all the required images. This is normal and may be because of the position of the baby or because your pregnancy is at a stage where it's hard to see some aspects of the baby because it is too early to see, such as the heart beat or certain parts of the baby's body. You may be asked to change your position, go for a walk or other movements throughout the examination to assist in changing the position of the baby which may or may not work. This is also a normal part of an obstetric ultrasound examination. Your sonographer will talk to you about any relevant exam issues.

You may need to have a follow up appointment or ultrasound exam. This may happen when the findings of the exam are unclear (e.g., because we are unable to get our standard views of the baby) or when another professional's expertise is required.

You can expect honesty, understanding, and kindness. We understand that everyone's situation and pregnancy is different, and we are here for you.

You can expect open communication, particularly in the event of unexpected findings. We will answer your questions to the best of our ability and follow up with colleagues when required. Please feel free to ask questions.

Should you need some time or a private space after your ultrasound exam, please let your sonographer know.

Appendix B – Lead-in Statements

It is important to use *"lead in"* statements in the event of adverse or unexpected findings. It is important to ensure that the overall message is value-free yet informative and honest.

The following examples are suggested statements only and may be used and adapted with professional discretion and judgment. Ensure other aspects of good communication are also established, as outlined earlier in these guidelines.

Examples of Lead in Statements:

Lead-in statements	1st Trimester (up to 12 weeks)	2nd Trimester	3rd Trimester
"Today's ultrasound exam has shown some unexpected findings (give details)."	✓	✓	✓
"[name of parent], the size of your baby does not match your pregnancy dates so I am going to discuss this with our reporting doctor and they will come in to discuss this further with you." Applies to the first trimester but also others because of growth restriction.	✓	✓	✓
"Although the baby is the right size for your dates, I cannot see the baby's heart beating as yet. This is sometimes the case at this early stage, therefore we will need to do another scan at a later date. We will let your doctor know of the findings so they can discuss this further with you."	✓		
"I spoke with the reporting doctor about not being able to get the pictures of the baby we need and [INSERT NAME] would like you to come back on [DAY and TIME] when Dr. INSERT NAME is here so we can look in more detail together."		✓	✓
"… so, I am going to ring our doctor now and discuss the results. I will come back as soon as I can to let you know what they've said to do pause to gauge reaction and respond appropriately based on cues from parent]" This does not apply to an ectopic pregnancy concern. It is in the setting of a miscarriage.	✓	✓	✓

“Part of the scan today involves looking at your baby’s developing organs. I have concerns with the appearance your baby’s INSERT ANATOMY” I am going to get more information for you from [who] as soon as I can - [how soon?].”	✓ *From 10 weeks	✓	✓
“We are going to make sure you have the information and the care you need. We will be with you every step of the way.”	✓	✓	✓
“I am sorry, I know you must be feeling anxious. But assessing your baby’s development is very important so I need to take some extra time to make sure we do the best we can for you and your baby.”		✓	✓
“I’m sorry XXXX, there is no heartbeat, this means that your baby has died.”	✓		
"Have you felt the baby move today?"		✓	✓
“How much has your baby been moving in the last 24 hours? Have these movements changed? When did you last see your doctor?"			✓
"Have you had any vaginal bleeding or loss of fluid lately?"			✓
As scanning, "I'm seeing a variation which is unexpected. I understand this news may be difficult right now" (be cautious with the use of the word’s such as problem in conditions such as T21 this is perceived as value-laden).	✓	✓	✓
Show the baby's chest, "This is your baby's chest and this is your baby's heart. I'm no longer seeing your baby's heart beating. I'm really sorry, your baby has died."		✓	✓

If you are not sure of findings:

Response	1st	2nd	3rd
"I don't seem to be able to get our standard views of the baby's INSERT ANATOMY. I'm not sure if it's just the baby's position today or something more. To make sure we are giving you and your baby the best care, I'd like to talk to the reporting doctor."	*From 10 weeks	✓	✓
"I've spoken with the reporting doctor. They would like you to come to our department (or other rooms) when Dr INSERT NAME is there. We will make sure this happens as soon as possible. Then we can look at your baby together. Our doctor will talk directly with you at the time and will answer any questions you may have. You might like to bring a support person with you. It might also be helpful to write down any questions you have."	*From 10 weeks	✓	✓
"This scan hasn't shown us clearly whether your baby's INSERT ANATOMY as expected for [insert gestation]. To make sure you and your baby get the best possible care, we'd like to arrange a follow up scan with [name of specialist/tertiary referral centre]." "We would typically expect to see XXXX but there is a difference here in the way the heart/brain/kidneys have developed. This difference may mean that the baby has XXX(condition/anomaly)" This is dependent on the level of confidence about the anomaly	✓ *From 10 weeks	✓	✓

In the case of a growth restricted baby or anomaly:

"With this ultrasound we are able to estimate your baby's weight by measuring the head, tummy and thigh bone. I've carefully measured these structures and the measurements are showing me that the baby is growing at a slower rate than we would like to see for this stage of the pregnancy. I am going to discuss this with my doctor and come back and talk with you about how we are going to look after you and your baby".

Anomaly

"When we look at your baby using ultrasound, each part of the baby has a typical appearance. I've looked closely at your baby's (insert name of structure) and I have noticed that the appearance on ultrasound is not what we usually see. Sometimes this is due to a normal variation in its structure or because of the angle of the ultrasound, and sometimes it's because there is a difference with the way it has developed".

Options:

1. "I am going to concentrate a little more while I look further and then talk with you about what I am seeing"
2. "I am going to get my doctor into the room and get them to have a look with me. Once they have looked at the scan, if they think there may be a concern, they will talk with you"
3. "I am unsure if there is a variation with your baby's (insert anatomy). To be sure, I think we should refer you to (insert name of unit) so they can review your baby. We will help set that appointment up for you. "
4. "I am noticing some variations with the development of your baby's (insert name of anatomy)," then explain what you are seeing in a calm and measured voice, while showing the parent on the screen with a pointer. "I know this will be a shock to you right now. I'm going to go and get the reporting doctor to have a look with me and we will..."

Appendix C – Terminology Considerations

It is acknowledged that every situation must be assessed on a case-by-case basis, due to variations in parents' personalities, clinical history, and sonographic results. Therefore, consideration of the parent's health literacy and ability to understand the words used in an explanation must be selectively worded to avoid any distress and misinterpretation of the findings.

Clear, unambiguous terms should be verbalised and, in some situations, written down to assist in the explanation, with careful consideration of the terms used to avoid psychological trauma.

The replacement of some words as recommended below are a guide only and ultrasound practitioners are encouraged to adapt the situation to ensure parents are satisfied and understand the findings. If an interpreter is needed this should be done as a priority before beginning any explanation.

Cautionary terminology	**Replacement Options**
Bad news	Unexpected finding
Failed pregnancy	Pregnancy loss
Embryo or fetus	Baby
Your baby has died (when used in isolation this is confronting and needs to be said in a supportive context)	I'm sorry, there is no heartbeat, this means that your baby has died.
Abortion	Pregnancy loss or miscarriage
Stigmatising terms like abnormality, malformation, problem, hole, faulty, wrong, defect and adverse finding in the case of variations.	Value-free terms like anomaly, difference, variation,
Risk	Chance, probability or likelihood
Leading the unexpected news with an apology for an **anomaly** by saying "I'm sorry" or "Unfortunately"	Empathise with the parents
Missed abortion	Pregnancy loss or miscarriage
Products of conception	Pregnancy tissue
Avoid anything that minimises a pregnancy loss – e.g., "at least it happened early in the pregnancy" "At least you already have another baby"	I'm sorry you are experiencing this loss, there are support organisations available that we recommend you get in touch with.

By using the words difference/unexpected, it moves away from the value-laden language of abnormality/defect. Similarly, by using the actual condition or anomaly name, the parent is able to go away and do some reading and find support groups.

Ambiguous or clinical explanations on areas beyond the scope of the ultrasound practitioner should be avoided.

Appendix D - Approval and Version History

Approval

Approver	Board of Directors
Date endorsed	23 February 2022
Date reviewed	N/A
Timeframe for next review	12 months

Version History

	Date	Action
1	23 February 2022	Created (published in March 2022)
2	29 June 2022	Additional endorsements received and acknowledged.

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