PERINATAL BEREAVEMENT IMMERSION FOR NURSES
PROVIDING CARE TO WOMEN WHO MISCARRY
IN THE EMERGENCY DEPARTMENT

by

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Caring for the family experiencing miscarriage may be one of the most stressful care circumstances an Emergency Department (ED) nurse encounters.

The fast-paced environment of the emergency department mean women receive physical care, but there is little time for attention to their unique emotional, spiritual and cultural needs.

Nurse confidence in the delivery of perinatal bereavement care (PBC) for women who miscarry in the ED may increase as a result of formal training in PBC.

There was a significant increase in nurses’ comfort and confidence to deliver care from pre-course \((M = 20, SD = 3.28)\) to post-course \((M = 29.5, SD = 2.5)\), \(t(88) = -11.35, p < .001\) (two-tailed).

Quality improvement measures provide an opportunity to align the standards of care for all women experiencing pregnancy loss regardless of gestational age at the time of the loss and location where medical attention is provided.

**Keywords**

Abortion Spontaneous, Miscarriage

Emergency Service Hospital, Education

Bereavement, Grief
Abstract

Purpose: To demonstrate that perinatal bereavement immersion for emergency department nurses increases knowledge and confidence in providing bereavement care to women who miscarry. Design and Methods: The quality improvement design employed the Resolve Through Sharing® Perinatal Death Bereavement Training model. The nurses’ perception of their knowledge and confidence was explored using the Resolve Through Sharing® Perinatal Death Bereavement Training Pre-Course and Post-Course Participant Survey. Results: The computed composite score for the pre and post-surveys was an unweighted sum of the individual participant responses to all questions. A paired-samples t-test was conducted to evaluate the impact of the training on nurses’ confidence in and knowledge of strategies to deliver bereavement care in miscarriage. There was a significant increase in their comfort and confidence to deliver care from pre-course ($M = 20, SD = 3.28$) to post-course ($M = 29.5, SD = 2.5$), $t(88) = -11.35, p < .001$ (two-tailed). The eta-squared statistic (.91) indicated a large effect size when interpreted using Cohen’s guidelines. Clinical Implications: Knowledge and confidence in the delivery of perinatal bereavement care to women who miscarry in the emergency department supports the autonomy of the ED nurse and promotes continuity of care for the patient and family. Interdepartmental collaboration aligns practice, policy, protocols and documentation between the labor and delivery unit and the emergency department. Extending training to nurses in all areas of the hospital provides a foundation for future scholarship.
Introduction

Caring for the family experiencing miscarriage may be one of the most stressful experiences an Emergency Department (ED) nurse will encounter. The reality is that due to the nature of the fast-paced environment and culture of most emergency departments, women are treated physically with little attention given to their unique emotional, spiritual and cultural needs.

Most ED nurses are not familiar with the principles and methodologies of perinatal bereavement care. They may fear that they will say the wrong thing, so they say nothing at all and may regularly call the experienced obstetrical nurse to assist with the particularly distraught patient. Grounded in a universal feeling of inadequacy, the ED nurse may panic, refuse or express reluctance to provide care to women experiencing a miscarriage.

The evidence demonstrates that nurse confidence in the delivery of perinatal bereavement care (PBC) for women who miscarry in the ED may increase as a result of PBC training. Introducing PBC training for ED nurses provides the foundation for quality improvement that also aligns the standard of care for all women experiencing pregnancy loss regardless of gestational age at the time of the loss, or location where medical attention is provided. In addition to meeting regulatory guidelines and improving the patient experience, ED nurses should participate in PBC so they are prepared to care for the unique emotional, spiritual and cultural needs of this population. The significant difference in the emotional and spiritual care provided to women who experience pregnancy loss, is a gap in practice that is best defined as the absence of or inconsistency
in the delivery of perinatal bereavement care to women who miscarry (pregnancy loss before 20 weeks) in the emergency department. This gap represents a disparity in the plan of care based on the gestational age compared to women experiencing loss after 20 weeks who receive care in the labor and delivery setting where PBC is the standard (Evans, 2012). Barriers to implementing perinatal bereavement care in the ED for women who miscarry relate to absent policy and protocols, the nurse’s inexperience and insufficient training in perinatal bereavement grief concepts, and the approaches and activities that validate the emotional and spiritual consequences of miscarriage (Burkey, 2014; Evans, 2012; Medeiros et al, 2013; Zavotsky, Mahoney, Keller, & Eisenstein, 2013). Emergency department nurses believe they should provide perinatal bereavement support but cite their lack of knowledge as the barrier to providing this care. When a woman miscarries in the emergency department (ED) and is especially distraught, the ED nurse calls a labor and delivery (L&D) nurse who is considered to be an expert resource, to provide perinatal bereavement support. The result is fragmentation in emergency nursing care and an interruption in patient care in L&D. When the L&D RN is not available to assist, emotional support and patient education are inconsistently delivered by untrained nursing staff, or not provided at all.

Advanced specialty education such as bereavement care provides in-depth knowledge and understanding. Knowledge increases RN confidence and enhances nursing practice thereby influencing the patient experience. The results of the studies reviewed, point towards bereavement education to build knowledge and confidence for
staff who care for grieving patients (Burkey, 2014; Evans, 2012; Medeiros et al, 2013; Zavotsky et al., 2013).

**Rationale**

Grief associated with miscarriage is especially difficult to resolve when there are no memories of a life to draw upon to ease the pain of the loss (Schott & Henley, 2009). When nurses validate miscarriage as a loss, they provide families with permission to grieve. Initiation of grief allows progression towards eventual resolution; conversely, without grief initiation, unresolved grief may result in disenfranchised grief (Canadian Paediatric Society Statement [CPSS], 2001). When the nurse validates a miscarriage as a loss and provides tender care illustrated through congruency in attitude and attention to emotional and spiritual needs, despite the devastation of losing a baby, the patient will speak highly of their nursing care (Evans, 2012; Zavotsky et al., 2013). Perinatal bereavement care (PBC) is essentially a mindset wherein there is a knowledge base and understanding of the fundamentals of grief expression and the behaviors and attitudes that demonstrate support that is unique to the loss of pregnancy (Wilke & Limbo, 2012). Principles and methodologies provide a foundation for focused language to support grief initiation. Bereavement care validates miscarriage as the loss of life, and teaches the healthcare provider to treat the products of conception (POC) with the same dignity and respect demonstrated when handling the remains of a pregnancy loss after 20 weeks. Respectful handling of the fetal tissue validates the pregnancy as the loss of life that is worthy of remembrance, and affords permission for the family to acknowledge their loss; this marks a starting point for their journey through grief (Burkey, 2014). Bereavement
activities such as naming and blessing encourage the family to participate in bonding activities that create memories. If indeterminate, offering karyotype and chromosomal studies will identify abnormalities and identify the sex of the fetus so the parents can provide a gender-appropriate name.

**Appraisal of the Literature**

Review of the literature was guided by the *Rapid Critical Appraisal Checklist for Descriptive Studies* (Melnyk & Fineout-Overholt, 2015). Due to the nature of the phenomenon inquiry, the majority of literature is qualitative and descriptive in nature. Descriptive studies attempt to illustrate the story, emotions and perceptions of an experience, told through the voice of the individuals who lived through it. The experience described is that of miscarriage and perceptions of the quality of care rendered by nurses. Also illustrated and emphasized in this review of the literature, is the nurse’s sensitivity towards bereavement care as a modality of care for miscarriage, and also, their readiness to deliver this care in addition to the identification of what they believed supported and promoted this care.

**Validity**

Qualitative, descriptive studies are appropriate to determine the reality and range or perceptions with healthcare providers in evaluating the patient experience. Seven studies were evaluated. Three were qualitative level 3 evidence, 1 was a meta-synthesis level 3 and 1 was a literature review level 5, and 1 quantitative, quasi-experimental level 2 (Evans, 2012; Rowlands & Lee, 2010; Medeiros et al, 2013; Burkey, 2014; Zavotsky et al., 2013). Overall, the sample size was small, $N=5$ (Medeiros et al., 2013), $N=9$
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(Rowlands & Lee, 2010). The measurement was oral reporting (Medeiros et al., 2013) and voluntary questionnaires of post discharged patients (Rowlands & Lee, 2010). The validity of responses received offers opportunity for bias related to the design of questions such as subjective, open-ended. Another area that challenges the validity of the model is the participant's voluntary involvement in the study. Furthermore, oral responses are subject to transcriber interpretation of the replies. Dissertation meta-synthesis evaluation, comprised of 14 studies, (five systematic reviews, two RCT’s, six descriptive qualitative and one non-experimental, correlational studies), albeit informative and most promising to provide credibility to the proposed practice change, the complete contents were not accessible and, therefore, did not withstand favorable appraisal (Burkey, 2014). Literature review samples were also of little statistical significance to support practice change. However, the qualitative, quantitative peer review of 44 publications did provide a historical overview of the phenomenon but failed to deliver details of the individual studies reviewed (Evans, 2012).

Explicitly stated in each study was the purpose, but the outcomes in the majority of studies demonstrated a significant correlation between specialized education and an increase in nurse confidence in delivering perinatal bereavement support. There were also multiple publications that identified a need for further research to provide credibility to mandate loss/counseling programs for staff nurses (Burkey, 2014; Rowlands & Lee, 2010).
Reliability

The results demonstrate the relationship between nurse confidence in their ability to provide bereavement care and patient satisfaction. A positive patient experience pivots on the behaviors that exhibit sensitivity and empathy (Burkey, 2014; Evans, 2012; Rowlands & Lee, 2010; Zavotsky et al., 2013).

Patient-Centered Care

Principles of patient-centered care (PCC) include assessment of grief and bereavement needs and should include the family’s coping and adaptation as well as addressing any barriers to grief progression (National Hospice and Palliative Care Organization [NHPCO], 2000-2010). Standard PFC 2.7 illustrates that there should be a process in place to assist in the transition of the family from medical care to bereavement care. Standard PFC 4.1, 4.3 and 4.4 acknowledge the family’s right to be informed of options in care, autonomy to determine care options, and the nurses’ obligation to incorporate the family’s preferences into the plan of care according to the family’s desired outcomes. Lastly, Standard PFC 9, 9.1, 12.1, 12.2 and 12.3 outlines the obligation of the RN to assess, incorporate and honor spiritual beliefs, traditions and rituals into care decisions as they relate to end-of-life. These Standards qualify as external variables that support the resolution and prevent complicated grief. (NHPCO, 2000-2010). Language, behaviors, and attitudes that validate miscarriage as the loss of life, also acknowledge the pain associated with miscarriage and support the transition through the initial phases of the grief trajectory to facilitate resolution (Sheehy, 2013).
Ethical Implications

By Provision 3.5 of the Code of Ethics (2015), the nurse is bound to identify practices that fail to serve the best interest of the patient and should incorporate industry standards and best practice (American Nurses Association, 2015). Provision 3.3 of the Code (2015) speaks of the employer’s obligation to provide education and resources for the nurse to meet job-related responsibilities. Best practice states that the RN should receive formal education in bereavement care. Principles of bereavement are beyond the scope of basic nursing education and should be considered a competency-based job requirement. Provision 1.3, 1.4 and 2.3 of the Code (2015) evokes thought that through informed decision, the nurse is responsible for acting as the patient agent in self-determination and autonomy. These Provisions come to life through the principles of bereavement care. Recognition of care deficits and clinical inquiry into best practice support quality improvements that relate to patient safety and outcomes. The pursuit of quality demands a synthesis of standards of care, the scope of practice and best evidence, and also considers the application of ethics (American Association of Colleges of Nursing, 2006).

Project Design and Methods

Using a quality improvement design, the ED nurses perception of knowledge and confidence in providing perinatal bereavement care was explored using the Resolve Through Sharing® Perinatal Death Bereavement Training Pre-Course and Post-Course Participant Survey (Gundersen Lutheran Medical Foundation, Inc. 2013). Results were analyzed using a paired-samples t-test and effect size was calculated to detect statistical
power. The paired-samples t-test evaluated the pre-survey to post-survey responses to detect changes for every answer for each participant.

Resolve Through Sharing® (RTS) was chosen as the intervention since it is evidence-based, meets regulatory and best practice standards for Joint Commission End of Life Care (2010), The Triple Aim Centers for Medicare and Medicaid and the Accountable Care Organization (ACO) Quality Measures. RTS provides the foundation of knowledge that supports consistent, precise delivery of perinatal bereavement care that speaks to Institute for Healthcare Improvement “Always Events” framework that is an optimal approach to patient and family care experiences.

A total of 10, 4-hour training sessions were offered on weekends and weekdays, with staggered starting times of 8 am, 12 noon, 5 pm and 8 pm. Four sessions were attended, while four were canceled. Each training incorporated five power point presentations. An introduction was followed by, *Resolve Through Sharing®, Bereavement Training in Perinatal Death, Relationship Through Ritual and Spiritual Care, Relationship in Practice: Giving Care (Ectopic) and Policies, Standard Operating Procedures (SOP) and Intranet* (Gundersen Lutheran Medical Foundation, Inc. 2012).

There were numerous opportunities for personal and professional reflection. Objectives included

1. Consider the roles of interdisciplinary teams with grieving families
2. Provide a theoretical framework for understanding attachment, grief, and loss
3. Relate grief theory to caring for bereavement parents
4. Demonstrate communication skills for interacting with grieving families

5. Describe appropriate interventions for responding to women and families who are experiencing a miscarriage in the ED with emphasis on cultural and spiritual consideration of the predominant populations served

6. Explain how children, family and friends are affected by miscarriage

7. Provide protocols and guidelines for consistent, sensitive care and follow-up after discharge

8. Identify the needs of the caregivers and describe ways to take care of themselves (BACPS, 2008, p. 2.2).

Training emphasized the joining of the principles and methodologies of perinatal bereavement care with an emphasis on how their care can have a positive impact on the patient experience in addition to resolving moral distress and unresolved caregiver grief. Participants were asked to reflect on Bunkers (2000) identified 16 foundational tenets of nursing knowledge, several which apply to the delivery of thoughtful perinatal bereavement care, namely:

1. Honoring human freedom and choice

2. Cultivating an attitude of openness to uncertainty and difference

3. Appreciating the meaning of lived experiences

4. Understanding the nature of suffering

5. Belief in the power of personal presence

6. Asserting the ethics of individual and communal responsibility

7. Emphasizing living in the present moment
8. Respecting life and nature


**Data Collection**

Immediately prior to and subsequent to immersion in the 4-hour Resolve Through Sharing® Perinatal Death training, participants were asked to complete the Resolve Through Sharing® Pre-Course and Post-Course Participant Surveys (Appendix B). The survey is a 5 point Likert-type survey consisting of 7 statements to which participants selected the most appropriate response of 1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree* and 5 = *strongly agree*. The statements elicited replies to the nurse’s perceived comfort, knowledge, and skills in providing perinatal bereavement care to families grieving the loss of their baby due to miscarriage. Participant identity and confidentiality were protected using a unique, 10 digit/alphabetical identifier.

**Sample**

Fourteen female emergency room registered nurses, ranging in ages and years of experience, working in a 178-bed rural community hospital in a Northeast state, volunteered to participate in this quality improvement project.

**Analysis**

A paired-samples t-test examined if there was a statistically significant change in the nurses’ reported confidence and aptitude to deliver perinatal bereavement care after completing the 4-hour training. Because this is a quality improvement study, these results can provide clinical staff with evidence to support joining this training with clinical
practice, especially for nurses working in the emergency department, or any unit where care is provided to women during or after a miscarriage.

The use of paired-samples t-tests must meet 3 key assumptions. Violation of these assumptions changes the conclusion of research and interpretation of the results. For that reason, care was taken to assess the data used in analysis against these assumptions.

First, the observations must be independent (i.e., nurses responses to the surveys must not be influenced by any other participant or the trainer). Participants received the pre and post survey and time was allowed for each individual to complete the surveys independently and quietly. Survey responses were not shared with or seen by anyone other than the researcher.

Secondly, data used must be distributed normally, meaning the results of participants in the sample fall symmetrically across the range of results. Declaring normality is an essential step in controlling errors in statistical analysis.

Both a histogram and the Shapiro-Wilk test for normality was conducted for all data elements used in the analysis. These data met the assumption of normality.

The third assumption for the use of the paired-samples t-test is that there is the homogeneity of variance which is the assumption that variances should be stable at all levels of another variable. For example, we would expect variations in the score to be similar at all ages or experience levels of nurses. The results of Levene’s test (1960) indicated the data used for this analysis met the assumption of homogeneity.
Results

An unweighted sum of the individual participant responses to all questions was computed for the pre and post-surveys. A paired-samples t-test was conducted to evaluate the impact of the training on nurses’ confidence in and knowledge of strategies to deliver bereavement care in miscarriage. There was a significant increase in their comfort and confidence to deliver care to a bereaved family from pre-course ($M = 20, SD = 3.28$) to post-course ($M = 29.5, SD = 2.5$), $t(88) = -11.35, p < .001$ (two-tailed). The eta-squared statistic (.91) indicated a large effect size when interpreted using Cohen’s guidelines (1988).

As this was a quality improvement project, the researcher performed a paired-samples t-test on each item and examined the pre and post-course surveys to detect topics or aspects of the training that were especially impactful.

There was a significant increase in the nurses' comfort with caring for bereaved families from pre-course ($M = 3.07, SD = .73$) to post-course ($M = 4.14, SD = .53$), $t(13) = -6.51, p < .001$ (two-tailed).

There was a significant increase in their knowledge to create a relationship with a bereaved family from pre-course ($M = 3.14, SD = .66$) to post-course ($M = 4.29, SD = .47$), $t(13) = -6.45, p < .001$ (two-tailed).

There was a significant increase in their skills to effectively communicate with a bereaved family from pre-course ($M=3.14, SD=.77$) to post-course ($M=4.36, SD=.50$), $t(13) = -5.67, p < .001$ (two-tailed).
There was a significant increase in their ability to *guide a family with end-of-life decision-making* from pre-course ($M=2.86, SD = .95$) to post-course ($M=4.0, SD = .56$), $t(13) = -4.94, p < .001$ (two-tailed).

There was a significant increase in their *understanding of how to use* interdisciplinary care for bereaved families from pre-course ($M=2.57, SD = .85$) to post-course ($M=4.21, SD = .58$), $t(13) = -8.25, p < .001$ (two-tailed).

There was a significant increase in their *knowledge to help create meaningful keepsakes with families* from pre-course ($M=2.21, SD = .89$) to post-course ($M=4.21, SD = .58$), $t(13) = -7.79, p < .001$ (two-tailed).

There was a significant increase in their *skills to help themselves and coworkers with their own grief* from pre-course ($M=3.0, SD = .55$) to post-course ($M=4.36, SD = .50$), $t(13) = -8.02, p < .001$ (two-tailed).

**Limitations**

The paired-samples t-tests do not prove that the training caused the results. However, it can assert that the training contributed to the improved self-perception. A notable limitation is that data are the participant’s perception of their skills and ability, and data are self-reported. The small sample size limits generalizing the results to a larger population. A potential limitation is the number of years in nursing practice and the qualification as a novice or expert nurse. Also, the participant’s personal experience with miscarriage may indirectly skew responses. Resolve Through Sharing® training provides knowledge. However, the ability to provide perinatal bereavement care may best be determined by experience, skill mastery and critical thinking ability.
Clinical Implications

This project is significant to nursing as it expands the knowledge base, confidence, and expertise in the delivery of perinatal bereavement care to women who miscarry in the emergency department. Specialty care principles unique to pregnancy loss supports the autonomy of the ED nurse, and nurse autonomy promotes continuity of care for the patient and family.

Conclusion

Emergency department nurses identify knowledge and confidence as a barrier to providing perinatal bereavement care. Evidence supports the efficacy of in-depth training to improve nurse confidence towards specialized care. Future research should concentrate on expanding the body of proof to support further increasing the ED nurses knowledge in perinatal bereavement care methodology and practices and broaden the opportunity to every nurse in all hospital, and clinic settings where women experiencing pregnancy loss receive medical care. Interdepartmental collaboration between the emergency department and labor and delivery aligned practice, policy, protocols, and documentation.
References


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APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University’s Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person’s ideas or works.

The following standards for original work and definition of plagiarism are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others’ work through proper citation and reference. Use of another person’s ideas, including another learner’s, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else’s ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University’s Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.
Statement of Original Work and Signature

I have read, understood, and abided by Capella University’s Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA Publication Manual.

Learner name and date
Joyce L. Merrigan January 11, 2017