

Interdisciplinary Guidelines for Care of Women Presenting to the Emergency Department with Pregnancy Loss

ABSTRACT: Members of the National Perinatal Association and other organizations have collaborated to identify principles to guide the care of women, their families, and the staff, in the event of the loss of a pregnancy at any gestational age in the Emergency Department (ED). Recommendations for ED health care providers are included. Administrative support for policies in the ED is essential to ensure the delivery of family-centered, culturally sensitive practices when a pregnancy ends.

KEY WORDS: emergency department, perinatal, perinatal loss, pregnancy loss, emergency room pregnancy loss, emergency department pregnancy loss, fetal remains, products of conception, physician, nurse, loss, death, grief, miscarriage, stillbirth, bereaved parent

DEFINITIONS:

Pregnancy Loss: For the purpose of this paper, the terms “products of conception,” “fetal remains,” “miscarriage,” “stillbirth,” and “baby” are used interchangeably, and the meaning of the pregnancy loss is determined by the family depending upon their own view.

Emotional Emergency: The term “emotional emergency” is used to describe an event that is traumatic emotionally and provokes an emergent need for support.

ABBREVIATIONS: ED - emergency department; ER - emergency room; D and C- dilatation and curettage; UNOS - United Network for Organ Sharing

INTRODUCTION: When a woman comes to the ED with the threatened or impending loss of a pregnancy at any gestational age, she is experiencing an event with emotional, cultural, spiritual, and physical components. A challenge exists in simultaneously providing treatment that is both physically and emotionally therapeutic, including holistic and spiritual support for the woman and her family, and providing bereavement care.

The following principles and practices are recommended:

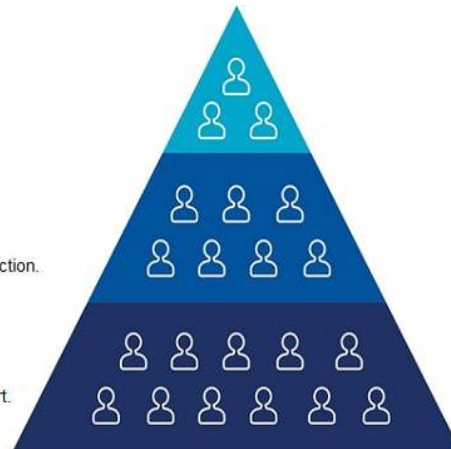
1. The ED health care team uses a relationship-based, patient-centered, family-focused, and team-oriented approach. The team provides personal, compassionate, and individualized support to women and their families while respecting their unique needs, including their social, spiritual, and cultural diversity.
2. The ED health care team provides effective, timely, attentive, and sensitive care to all dying patients and their families, including families experiencing a perinatal death. This care is defined as anticipation and management of all symptoms related to the death or impending death of an unborn or prematurely born baby and the provision of physical, emotional, and spiritual comfort to the woman and her family.
3. The ED health care team provides a coordinated response, including sensitive triage as an “emotional emergency” and a potentially serious physical event.

4. The ED health care team should provide privacy and safety for the woman and family. A suggested location is the room where private or forensic pelvic exams are done.
5. Each facility should use a recognizable marker that designates pregnancy loss. The marker may be used on the room, stretcher, bed, medical record, or any other item deemed appropriate. All health care personnel (medicine, nursing, social work, chaplaincy, lab, ultrasound, radiology, transport, etc.) should be taught to recognize this marker and provide sensitive care in response.
6. Ultrasound and transport to ultrasound to confirm perinatal death should be done with dignity and compassion, and the presence of a loved one, support person, or advocate should be encouraged.
7. Bad news should be delivered with compassion and concern, and how to do so effectively should be included in the training of all health care providers. Cultural sensitivity and individual circumstances are important; some families may not consider this to be a loss and others may be deeply affected. To determine the pregnancy loss meaning, providers can simply ask, "How are you feeling about this?" If the provider is uncomfortable, enlisting the assistance of a colleague is recommended.
8. Many families consider perinatal loss to be as significant as the loss of a living child. Providers should attempt to determine how the woman and family consider this loss, i.e., do they view the end of this pregnancy as a minor event or do they view this as the significant loss of a baby?
9. The ED health care team should identify and notify the obstetric provider (if one exists) of the death or potential death. This is important for follow up obstetric care and to avoid having the woman continue to receive communications from the provider regarding prenatal screening tests and pregnancy classes when she is no longer pregnant. Also, the provider may wish to order specific testing on the mother or fetus.
10. Sorrow for the pregnancy loss should be expressed by anyone in close contact with the family, unless all family members have stated that this is not a sorrowful event to them.
11. When providing physical care of the woman, the provider should tell her what to expect in terms of the normal clinical course of post-pregnancy loss recovery, including vaginal discharge, possible lactation and breast care, hormonal changes and their effects, and postpartum depression and anxiety. Sanitary napkins and ice packs may be provided for home care. Women should be told that they should see a health care provider as soon as possible if the following occurs: significant bleeding, such as clots the size of a plum, accompanied by lightheadedness or fainting; fever; or foul-smelling discharge or uterine tenderness. These directions should be included in after-care discharge instructions.
12. If a woman needs a dilatation and curettage (D and C) procedure, it is recommended that this be done in a sterile and calm environment outside of the emergency department. If the procedure must be done in the ED, the woman should have access to the same level of comfort, sedation, and nursing support as is the standard of care outside of the ED.
13. Some families may wish to bury the remains of a baby after a D and C. Products of conception should not be discarded automatically with medical waste without prior discussion with the woman.

14. Patients and families should be given specific information for dignified disposition of any product of conception. This discussion is now mandated by law in several states. Patients and families should have choices about taking fetal remains home; having them buried or cremated; or leaving them at the hospital for respectful disposition according to local, state, and federal laws. In some states, remains can be released only to a funeral home that would then involve the family in decision making. When hospital staff members are transporting miscarried babies or remains to the laboratory or the morgue, this should be done with respect, in the same quiet and dignified manner that an adult body would be transported.
15. If the pregnancy does not end in the ED and patient is sent home to “watch and wait,” the ED team should fully inform her about what may happen physiologically if the pregnancy does come to an end, and at what point she might want to return to the hospital or her health care provider. The team should explain how to use a hat or strainer when using the toilet, in case tissue, baby, or placenta is passed. Such collection items should be offered to the mother in a convenient and dignified manner. Simple written instructions in the mother’s preferred language are essential.
16. Emotional support can be given as adapted from the Kazak’s (2006) Pediatric Preventative Psychosocial Health Model. All women may be given grief and bereavement materials from organizations listed below.

Adapted from Stepped Care Pyramid, Kazak, 2006

- **Clinical/Treatment Level**
Woman is experiencing persistent or escalating distress.
High risk factors.
Referral is made to trained mental health professional.
- **Targeted Patients**
Woman is in acute distress.
Hospital Chaplain or Social Worker is called to assist.
Perinatal Bereavement Counselor makes follow-up connection.
- **Most Patients - Universal Emotional Support**
Women and families may be distressed but are resilient.
Nurses and Physicians in the ED offer comfort and support.



17. Specific education regarding the management of loss of a desired pregnancy should be provided to all ED personnel, including physicians, nurses, and technicians; and all trainees, such as emergency medicine, obstetric, and pediatric residents, medical students, nursing students, and emergency nurse orientees. Education should include:
 - Giving the news in a culturally competent, compassionate, supportive, and honest manner

- Assessing the meaning of the pregnancy loss to the woman and family, and directing care accordingly
- Informing the family that grief takes different forms and timeframes for each culture and each individual within a culture, and giving them permission to grieve in their own way
- Providing support with decision-making about procedures, family involvement, memory-making, and saying goodbye
- Providing names and contact information for local grief counselors or pregnancy loss support groups and community caregivers dedicated to pregnancy loss support

18. Grieving parents and their families can be offered bereavement care. This can include cultural or spiritually appropriate support, such as a baptism or blessing. Parents may wish to take pictures and a digital camera in the ED may be helpful. Skin-to-skin holding, bathing and wrapping the baby in blankets or dressing the baby in specially made clothing may be appropriate. Families can be provided a memory box which may have a lock of hair, hand and foot prints, or other keepsakes.

19. In most cases of pregnancy loss at greater than 20 weeks' gestation, women are transferred to the maternal child department, where bereavement support is available. In cases in which the patient will remain in the ED for the duration of care, ED personnel should know the processes for:

- Completion of state-mandated birth, death, and/or stillbirth certificates
- Contacting the state UNOS organization, if gestation allows for consideration of organ or tissue donation
- Policy related to sending the placenta/cord to Pathology
- Maternal toxicology screen, if indicated by locale
- Lab work for genetic or other studies
- If gestational age permits, discussion of full or partial autopsy of the body or placenta and obtainment of necessary consent
- Discussion related to disposition of remains in a culturally competent and sensitive manner that offers all options legal in the state, and provision of written materials related to dispositions that are written at patient's literacy level
- Information regarding hospital memorial services and/or burial ceremonies, if available

20. Ongoing perinatal bereavement care in-services should be available, and materials such as supplies and policies and procedures should be reviewed. Many of the following organizations provide pregnancy loss training for ED personnel. All provide selections of written material that may be ordered for patients.

- Gundersen Health System Resolve Through Sharing (<http://www.ResolveThroughSharing.org>)
- Share Pregnancy & Infant Loss Support, Inc. (www.nationalshare.org)
- A Place to Remember (www.aplacetoremember.org)

- Babies Remembered (www.BabiesRemembered.org)
- Centering Corporation (www.centering.org)
- The Miscarriage App (a mobile phone application for iPhone and Android phones)
- Position Statements and Practice Guidelines for health care practitioners from the Pregnancy Loss and Infant Death Alliance (www.PLIDA.org)

21. Hospitals should provide the ED with human resources to assist the ED team, such as a perinatal bereavement team member, chaplain, social worker, behavioral health staff, maternal child nurse, and hospice or palliative care staff. The assigned bereavement coordinator within or outside of the ED may follow up with a phone call to the family at one week and text, email, or phone the family at one month.

22. Emotional support for ED staff who care for these patients and families is important. Staff should ask for help in an immediate situation if needed. Debriefing after a difficult loss situation is encouraged. Self-care is essential for ED personnel who often have difficult or troubling cases. The hospital chaplain or social worker should be called on as needed. An appointment with the facility's Employee Health may be helpful.

References:

Kazak, A. E., Kassam-Adams, N., Schneider, S., Zelikovsky, N., Alderfer, MA., & Rourke, M. (2006). An Integrative Model of Pediatric Medical Traumatic Stress. *J. Pediatr. Psychol.* 31 (4): 343-355.

Bibliography

Arshad, M., Horsfall, A., & Yasin, R. (2004). Pregnancy loss – the Islamic perspective. *British Journal of Midwifery* 12(8), 481-484.

Adriaenssens, J., De Gucht, V., Van Der Doef, M., & Maes, S. (2011). Exploring the burden of emergency care: predictors of stress-health outcomes in emergency nurses. *Journal of Advanced Nursing* 67(6), 1317-1328.

Bacidore, V., Warren, N., Chaput, C., & Keough, V. A. (2009). A collaborative framework for managing pregnancy loss in the emergency department. *Journal of Obstetric, Gynecological & Neonatal Nursing* 38(6), 730-738.

Bielkiewicz, G. M. (2002). Theories from the sociologic sciences. In M. McEwen & E.M. Wills, *Theoretical Basis for Nursing* (278-304). Philadelphia: Lippincott Williams & Wilkins.

Brier, N. (2008). Grief following miscarriage: A comprehensive review of the literature. *Journal of Women's Health* 17(3), 451-464.

Burns, C., & Harm, N. J. (1993). Emergency nurses' perceptions of critical incidents and stress debriefing. *JEN: Journal of Emergency Nursing* 19(5), 431-6.

Busta-Moore, D., & Catlin, A. C. (2003). Lactation Suppression: Forgotten aspect in care of the mother of a dying child. *Pediatric Nursing* 29(5).

- Catlin, A. J. (1989). Early pregnancy loss: what you can do to help. *Nursing* 19(11), 43.
- Fu-Hsuan, C., & Wen-Yu, H. (2013). The Impact of Perinatal Death on Nurses and Their Coping Strategies [Chinese]. *Journal Of Nursing* 60(1), 87-91.
- Côté-Arsenault, D. & Denney-Koelsch, E. (2011). "My Baby Is a Person": Parents' Experiences with Life-Threatening Fetal Diagnosis. *Journal of Palliative Medicine* 14(12), 1302-1308.
- Côté-Arsenault D. (2003). Weaving babies lost in pregnancy into the fabric of the family. *Journal of Family Nursing* 9(1), 23-37.
- Côté-Arsenault D. (2007). Threat appraisal, coping, and emotions across pregnancy subsequent to perinatal loss. *Nursing Research* 56(2), 108-16.
- Côté-Arsenault, D. & Donato, K. (2011). Emotional cushioning in pregnancy after perinatal loss. *Journal of Reproductive & Infant Psychology* 29(1), 81-92.
- Covington, D. & Rickabaugh, B. (2006). Caring for a patient with a spontaneous abortion. *Journal of Emergency Nursing* 32(6), 513-515.
- Craig, D. V. (2009). *Action Research Essentials*. San Francisco: Jossey-Bass.
- Dougherty, N. (1994). Better ways to treat women with miscarriages: Using a patient complaint to improve emergency department care. *Journal of Emergency Nursing* 20(6), 521-527.
- Emergency Nursing Association. (2011). The obstetrical patient in the emergency department. Position Statement. Des Plaines, IL.
- Evans, R. (2012). Emotional care for women who experience miscarriage. *Nursing Standard* 26(42), 35-41.
- Fry, M. (2012). An ethnography: Understanding emergency nursing practice belief systems. *International Emergency Nursing Journal* 20(3), 120-125.
- Gold, K. J. (2007). Navigating care after a baby dies: A systematic review of parent experiences with healthcare providers. *Journal of Perinatology* 27(4), 230-237.
- Holloway, I. & Wheeler, S. (2010). *Qualitative Research in Nursing and Healthcare*. West Sussex, UK: Wiley-Blackwell.
- Hughes, K., & Goodall, U. A. (2013). Perinatal bereavement care: Are we meeting families' needs? *British Journal of Midwifery* 21(4), 248-253.
- Hutti, M. H., dePacheco, M., & Smith, M. (1998). A study of miscarriage: development and validation of the Perinatal Grief Intensity Scale. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 27(5), 547-55.
- Johnson, O., & Langford, R. (2010). Proof of life: a protocol for pregnant women who experience pre-20-week perinatal loss. *Critical Care Nursing Quarterly* 33(3), 204-211.

- Kilcoyne, M., & Dowling, M. (Dec 2007-Feb 2008). Working in an overcrowded accident and emergency department: nurses' narratives. *Australasian Journal of Advanced Nursing* 25(2), 21-27.
- Kobler, K., Limbo, R., & Kavanaugh, K. (2007). Meaningful moments: the use of ritual in perinatal and pediatric death. *MCN, The American Journal of Maternal Child Nursing* 32(5), 288-97.
- Koziol-Mclain, J., Whitehill, C. S., Stephens, L., O'Flaherty, E., Morrell, M., & Chapman, M. (1992). An investigation of emergency department patients' perceptions of their miscarriage experience. *Journal of Emergency Nursing* 18(6), 501-504.
- Kuebelbeck, A., & Davis, D. L. (2011). *A Gift of Time, Continuing Your Pregnancy When Your Baby's Life is Expected to Be Brief*. Baltimore: Johns Hopkins.
- Lang, A., Fleiszer, A.R., Duhamel, F., Sword, W., Gilbert, K. R., & Corsini-Munt, S. (2011). Perinatal Loss and Parental Grief: The Challenge of Ambiguity and Disenfranchised Grief. *Omega: Journal of Death & Dying* 63, 183-196.
- Lee, C. (2012). "She was a person, she was here": The experience of late pregnancy loss in Australia. *Journal of Reproductive & Infant Psychology* 30(1), 62-76.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.
- Lindberg, C., Nash, S., & Lindberg, C. (2009). *On the Edge: Nursing in the Age of Complexity*. Persphone Press.
- Limbo, R., Glasser, J. K., & Sundaram, M. E. (2014). "Being Sure": Women's experience with an inevitable miscarriage. *MCN, The American Journal of Maternal/Child Nursing* 39(3), 165-174.
- Limbo, R., Kobler, K., & Levang, E. (2010). The respectful disposition in early pregnancy loss. *MCN, The American Journal of Maternal/Child Nursing* 35(5), 116-122.
- Limbo, R., & Kobler, K. (2010). The tie that binds: relationships in perinatal bereavement. *MCN, The American Journal of Maternal/Child Nursing* 35(6), 316-321.
- Murphy, F., & Merrill, J. (2009). Negotiating the transition: Caring for women in the experience of early miscarriage. *Journal of Clinical Nursing* 18(11), 1583-1591.
- Nallen, K. (2004). Bereavement support – a concept analysis. *Midwifery Digest* 14(3), 313-319.
- NANN (2010). Palliative Care for Newborns and Infants Position Statement #3051. National Association of Neonatal Nurses.
- Olson, Kelly Jo. (2013). Health Promotion: Healing Through Loss. *JEN: Journal of Emergency Nursing* 39(6), 610-612.
- NPA National Perinatal Association (2013). Position Statement on Palliative Care. Retrieved at <http://nationalperinatal.org/Resources/Palliative%20Care%20%2012-12-13.pdf>
- Redman, C. (2003). Counseling in perinatal loss. *British Journal of Midwifery* 11(12), 731-734.

- Ross-Adjie, G. M., Leslie, G., & Gilman, L. (2007). Occupational stress in the ED: What matters to nurses? *Australasian Emergency Nursing Journal* 10, 117-123.
- Sawatzky, J. V., & Enns, C. L. (2012). Exploring the key predictors of retention in emergency nurses. *Journal of Nursing Management* 20, 696-707.
- Stead, C. E. (1996). Nursing management in the accident and emergency department of women undergoing a miscarriage. *Accident and Emergency Nursing* 4, 182-186.
- Swanson K. (1993). Nursing as informed caring for the well-being of others. *IMAGE* 25(4), 352-357.
- Swanson, K., Connor, S., Jolley, S., Pettinato, M., & Wang, T. (2007). Contexts and evolution of women's responses to miscarriage during the first year after loss. *Research In Nursing & Health* 30(1), 2-16.
- Wilke, J., & Limbo, R. (2012). Bereavement Training In Perinatal Death. Resolve through Sharing Manual. Bereavement Services Gundersen Health System.
- Esposito-Woods, J. L., & Woods, J. (1997). *Loss During Pregnancy or in the Newborn Period*. New Jersey: Anthony Jannetti Press.
- Wool, C. (2013a). State of the science on perinatal palliative care. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 42(3), 372-82.
- Wool, C., & Dudek, M. (2013b). Exploring the perceptions and the role of genetic counselors in the emerging field of perinatal palliative care. *Journal of Genetic Counseling* 22(4), 533-43.
- Wool, C. (2013c). Clinician confidence and comfort in providing perinatal palliative care. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 42(1), 48-58.
- Wool, C., & Northam, S. (2011a). Perinatal palliative care perceptions and barriers scale instrument: Development and validation. *Advances in Neonatal Care* 11(6), 397-403.
- Wool, C. (2011b). Systematic review of the literature: Parental outcomes after diagnosis of a fetal anomaly. *Advances in Neonatal Care* 11(3), 182-92.
- Zavotsky, K. E., Mahoney, K., Keeler, D., & Eisenstein, R. (2013). Early pregnancy loss and bereavement in the emergency department: staff and patient satisfaction with an early fetal bereavement program. *Journal of Emergency Nursing* 39(2), 158-161.

Endorsements

Endorsements

The Pregnancy Loss and Infant Death Alliance (PLIDA) endorsed this statement at their 20th International Perinatal Bereavement Conference September 28 – October 1, 2016.