

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.

Definitions:

- **Pregnancy Loss:** Depending on what the ending of a pregnancy means to a woman, any of the following terms may be appropriate: products of conception, fetal remains, miscarriage, stillbirth, and baby.
- **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.¹⁻⁹ 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:

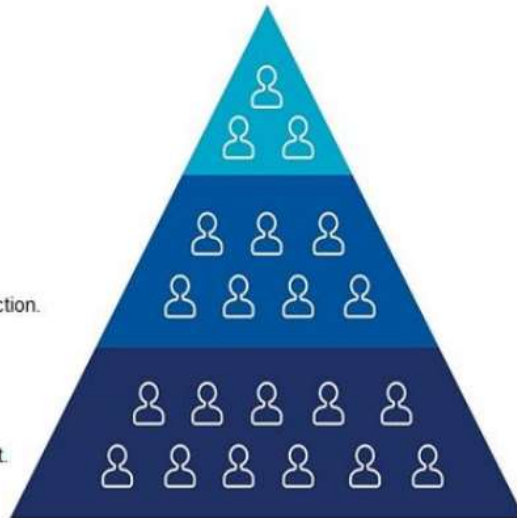
1. The ED health care team uses a relationship-based, patient-centered, family-focused, and team-oriented approach. The team provides personal, compassionate, and individualized support to women and their families while respecting their unique needs, including their social, spiritual, and cultural diversity.¹⁰⁻¹¹

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.¹²
3. The ED team provides a coordinated response, including sensitive triage as an “emotional emergency”¹³⁻¹⁴ and a potentially serious physical event.
4. The ED health care team should provide privacy and safety for the woman and family.¹⁵⁻¹⁶ 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.¹⁷ The marker may be used on the room, stretcher, bed, medical record, or any other item deemed appropriate. All health care personnel (e.g., medicine, nursing, social work, chaplaincy, pathology, laboratory, ultrasonography, radiology, and patient transport) should be taught to recognize this marker and provide sensitive care in response.
6. Transportation to and from 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.¹⁷ To determine the pregnancy loss meaning, providers can simply ask, “How are you feeling about this?”¹⁸ 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.^{3, 6, 19} 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. An Rh immunoglobulin injection is ordered as is policy of that institution.²⁰

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,²¹ including vaginal discharge, possible lactation and breast care,²² hormonal changes and their effects, and postpartum depression and anxiety. Sanitary napkins and ice packs may be provided for home care. After-care instructions should include being told that they should see a health care provider as soon as possible if the following occurs:²³ significant bleeding, such as clots the size of a plum, accompanied by lightheadedness or fainting; fever; or foul-smelling discharge or uterine tenderness.
12. If a woman needs a dilatation and curettage (D and C) procedure,²⁴ 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.²⁵
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 and countries.²⁶ 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.²⁷ 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 preferred language are essential.
16. Emotional support can be given as adapted from the Kazak’s Pediatric Preventative Psychosocial Health Model.²⁸ 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 education¹⁷ 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 way¹⁸
 - Teaching how nurses and providers can learn to feel comfortable with showing products of a miscarriage or fetal loss to a woman or her family should she ask for this (See further description in Table 1).
 - 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. Other options are available for babies of larger sizes. 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.²⁹⁻³¹

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 tissue or organ 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, a gentle 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.gundersenhealth.org/resolve-through-sharing>)
 - SHARE Organization (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.¹⁷

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.³² 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.

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History of how this position statement was created can be found in Catlin, A. (2017). Creation of Interdisciplinary Guidelines for Care of Women Presenting to the Emergency Department with Pregnancy Loss. *Journal of Perinatology*, in press.

Participants in the National Perinatal Association Summit that created these guidelines can be found in Catlin, A. (2017). Interdisciplinary Guidelines for Care of Women Presenting to the Emergency Department with Pregnancy Loss. *MCN, The American Journal of Maternal Child Nursing*, in press.

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Table 1. Recommendations for ED Nurse on Seeing and Showing After Miscarriage

Seeing and Showing

Some women choose to see and/or hold the remains after a miscarriage; others do not. As she is making that decision, hearing someone say, “I don’t think you should” or “We don’t allow that here,” or, trying to induce her to hold the baby when she prefers not to, can be harmful. Such statements may increase the woman’s sense of powerlessness and create a lifetime of wondering. Patients often wonder how the remains/baby will be cared for following miscarriage. You could say, “The baby will go to the laboratory (in some facilities this is the morgue). The transport will be made with dignity and we have this specially designed fabric bag for the transport.” You can say, “You can see your baby whenever you want.” The facility may be working towards an annual burial service or have one for inclusion of the remains.

Contents of the Uterus after a Loss

In order to anticipate what the remains will look like, the nurse or health care provider reflects with the pregnant woman on what she can expect to see: How many weeks’ gestation was the pregnancy (the longer the pregnancy, the greater the likelihood of a visible baby)? In early pregnancy, there may be only blood clots, perhaps the size of a plum, whitish tissue and watery fluid. How long has the baby been dead, or how long has the pregnancy been over, or how long did it take to have the miscarriage (A pregnancy over for a period of time may result in a macerated product and decomposing of conception when passed)? If the diagnosis of this miscarriage was a “blighted ovum,” this means there was no fetal pole and the embryo/fetus did not develop. The uterus appears empty on ultrasonography. Therefore, there would be no embryo or fetus, but there could be placental tissue. If gestation continued for a significant period, there will be a formed fetus or baby that is passed.

Careful explanation from the provider can set the tone. A sensitive statement from the nurse or care provider would be, “I want to help you be prepared for what you will see. Based on what has happened so far, what are you expecting the remains/your baby to look like?” Then verify or clarify. “Because your miscarriage happened so early, you usually will see tissue, blood, liquid, and maybe a formed (but very tiny) baby. I will let you know what you will see so you feel prepared, and I will be with you if you’d like me to be.” Or “Because this miscarriage happened late, there will be a very small baby to see.”

Viewing Uterine Contents after Surgical Intervention

Surgery (dilation and curettage; dilation and evacuation) typically results in the tissue being disrupted so that an identifiable baby comes out in parts. It might be difficult to see this for both the staff member and the woman. Some nurses have made footprints for the mother

when possible as a cherished memento. Respectful handling of tissue after miscarriage or surgery includes placing the remains on something soft (blanket, gauze) or within a special box with a blanket. You might say “We have a special purple box with a tiny blanket inside for your baby’s remains. “

Guidelines for Working with Laboratory and Morgue Staff

If one or both parents wish to see the baby after an identifiable embryo/fetus/baby has been placed in formalin in the laboratory or morgue, the most important aspect of this viewing is that the baby’s body first be placed in 100% alcohol for a period of time.

Formalin darkens skin tones; alcohol returns the skin to its normal color (the larger the body, the longer this takes). This requires written guidelines regarding rinsing the baby’s body if it has been in formalin; guidelines for parents who wish to remove the baby from the laboratory; checking on state and hospital guidelines, and establishing strong, enduring relationships with laboratory/morgue staff. Those who work in the laboratory or morgue should understand the tremendous difference they can make in the lives of parents.

The Importance of Respectful Disposition

Clinical experience and research consistently demonstrate that anything that could be interpreted as disrespectful to the parents’ baby should always be avoided when showing the remains, such as use of emesis basins, buckets, bedpans and suction canisters. If you do not have a special box or blanket, use something soft, such as gauze or a soft cloth. Even if your ED has only curtains separating one patient from another, provide privacy through a soft tone of voice, being seated, engaging both parents or the mother and her support person, assess the meaning of the miscarriage (e.g., if the woman/mother uses the term “baby” or “my baby,” then the provider should use those terms as well--but not before the patient/mother does).

Explain when questions are asked, but avoid talking nonstop while the parents are being with their baby. Ask, “Would you like me to step out for a few minutes so you have some time alone?”

This single snapshot memory stays with parents for a lifetime.

Compassionate and respectful care in this singular moment when they see their baby who was miscarried are critical. Hold in mind that you are a part of a time in your patient’s life in which she knows very little of what to expect. She will remember always the difference you made.

Author Table 1: Rana Limbo, PhD, RN, CPLC, FAAN, Resolve Through Sharing®, with assistance from Cathy Mikkelson Fisher, MA, ELS and Anita Catlin, DNSc, FNP, FAAN (editing) and Marie Walter, MS, RN, CPLC (content).

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