JOGNN

RESEARCH

# Experiences of Nurses Who Care for Women After Fetal Loss

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**Keywords**
caring
fetal loss
nurses

## ABSTRACT

**Objective:** To examine the experiences of, meaning for, and personal consequences for obstetric, emergency, and surgical nurses caring for women after fetal death and to determine how these nurses use Swanson's caring processes in providing such care.

**Design:** Four focus groups.

**Setting:** Two hospitals within the same health care system.

**Participants:** Registered nurses ($N = 24$) working in the obstetric, surgery, or emergency departments.

**Methods:** Swanson's Theory of Caring guided focus group questions that were audiotaped and transcribed verbatim. Data were analyzed using a continuously emergent process of data collection, data reduction, data display, and interpretation.

**Results:** All participants demonstrated all of Swanson's caring processes but used them preferentially according to situational exigencies and level of rapport with each woman. Nurses had positive and negative feelings associated with caring for women after fetal loss.

**Conclusions:** Obstetric nurses provided relatively equal focus on all processes in the Theory of Caring except *Maintaining Belief*. Surgical and emergency department nurses focused primarily on the caring processes of *Knowing* and *Doing For*. The negative feelings reported by nurses mirror some emotions commonly associated with compassion fatigue. More research is needed to determine whether nurses caring for mothers experiencing fetal loss are at risk for compassion fatigue. Research is also needed to identify strategies and interventions to help nurses so they may continue to give the best care possible to these very vulnerable families without detriment to themselves.

*JOGNN, 45, 17–27; 2016.* http://dx.doi.org/10.1016/j.jogn.2015.10.010

Accepted October 2015

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The authors report no conflict of interest or relevant financial relationships.

Hospital-based nurses from many specialty areas care for women who experience fetal loss, including obstetric (labor & delivery [L&D], antepartum, and mother/baby units [OB]), surgery (operating room [OR] and postanesthesia units [PACUs]), and emergency departments (EDs). Although nurses from various specialties often find caring for grieving women rewarding, it can be emotionally difficult as well (Chan, Wu, Day, & Chan, 2005; Roehrs, Masterson, Alles, Witt, & Rutt, 2008). Even with additional education on bereavement care, nurses may feel uncertain and ill-prepared to provide high quality care to grieving women (Ramsden, 1995; Wallbank & Robertson, 2008).

Little is known about the effect that caring for women and families after the trauma of fetal death has for the nurses who provide such care. In limited studies, researchers found that OB nurses may suffer a wide range of responses in this scenario, including crying, sadness, anger, intense sorrow, nightmares, guilt, grief, and fear (McCreight, 2005; Wallbank & Robertson, 2008; Wallbank, 2010). We were not able to locate published research about how ED and surgical nurses respond to caring for these women, even though ED nurses provide the most care to women with early fetal loss (Zavotsky, Mahoney, Keeler, & Eisenstein, 2013). Nurses who must care for multiple women experiencing fetal losses are considered to be at risk for developing work-related psychological disorders (Regehr & Bober, 2005; Leinweber & Rowe, 2010). Over time, nurses who provide care to those women may find themselves unable to cope with their distress (McCreight, 2005).

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## Background and Significance

Early and late fetal death, including miscarriage and stillbirth, occur in about 25% of all pregnancies (Hutti, Armstrong, & Myers, 2013). *Miscarriage* is the death of a fetus before 20 weeks gestation; *stillbirth* is the death of a fetus after 20 weeks gestation but before birth (Kersting & Wagner, 2012). The overall prevalence of miscarriage in pregnancy varies from 15% to 75%, depending on the age of the pregnant woman, and the greatest risk is associated with women older than 45 years (Adolfsson, 2011). Approximately 2% of all pregnancies result in stillbirth (Hutti, Armstrong, & Myers, 2011). It is estimated that approximately two million women are affected by fetal death annually in the United States (Côté-Arsenault & Donato, 2007). In most hospital settings, ED nurses provide care for women who experience fetal losses before 16 to 20 weeks gestation, whereas women who experience stillbirth are cared for by OB nurses (Zavotsky et al., 2013). Any woman who requires a surgical procedure such as a dilation and curettage or dilation and evacuation after a fetal death is cared for by a surgical nurse.

Fetal death may cause significant grief reactions in parents (Hutti et al., 2011). Women who experience fetal death have strong preferences regarding the way their care is managed by health care providers and report significantly less satisfaction with care when they are not treated according to those preferences (Hutti, 1992, 2005). Women who experience fetal death may also feel victimized and respond with anger to inappropriate care (Hutti, 1992, 2005; Hutti et al., 2013), which may add to women's feelings of grief and trauma (Hutti, 1992; Hutti et al., 2013).

Fetal death may also be a traumatic event for the nurse who provides care. Limited research has been conducted to evaluate the effect that caring for women after a fetal loss has on nurses. In a study of 169 nurses, positive attitudes about care after perinatal loss were associated with previous bereavement education, supportive colleagues, and hospital policies that were supportive of nurses who provided bereavement care (Chan et al., 2005). McCreight (2005) interviewed 14 nurses in a qualitative study to explore nurses' educational preparation for perinatal bereavement care. She found that bereavement education and excellent communication skills were critically important for nurses who provide this care. She and other nurse leaders support hospital policies that place value on these aspects of nursing practice (Kavanaugh & Paton, 2001; Tseng, Hsu, & Kuo, 2001).

Roehrs et al. (2008) conducted a qualitative study with 10 L&D nurses to explore their lived experiences of caring for families after a perinatal loss. Participants were generally comfortable but found it difficult to provide perinatal bereavement care. Jonas-Simpson, Watson, McMahon, and Andrews (2010) conducted an exploratory, qualitative study to examine how OB nurses experienced caring for families after a fetal loss. Ten registered L&D nurses participated in an in-depth, semistructured interview lasting 30 to 90 minutes and reported a longing for understanding and time to reflect and share with others to have the strength to go on. They wanted formal and informal time for peer support. Perinatal bereavement education was considered essential to help alleviate nurses' fear of saying or doing the wrong thing. Nurses believed it was critical to assign nurses who were emotionally prepared to care for families experiencing a fetal loss and to be sensitive to those nurses who may be feeling too vulnerable to provide bereavement care on a particular day. Finally, ensuring adequate time and resources was identified as a way to help nurses provide individualized, high-quality care to grieving families (Jonas-Simpson et al., 2010).

Working with grieving families is challenging and difficult, and it requires a high level of skill. In most OB units, nurses receive specialized unit-based training beyond their basic educational preparation to provide care to bereaved women and their partners. In addition, inexperienced nurses often receive role modeling regarding bereavement care from more experienced nurses (Gardner, 1999). However, ED nurses generally do not receive specialized perinatal loss training (Ramsden, 1995), even though 1% to 2% of all ED visits involve miscarriage (Warner, Saxton, Indig, Fahy, & Horvat, 2012).

Annually, ED nurses provide care to approximately 175,000 women for pregnancy loss (Bacidore, Warren, Chaput, & Keough, 2009). The focus of the ED is the diagnosis and treatment of disorders