Developing a Process to Support Perinatal Nurses After a Critical Event

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Nurses have always been in the position of caring for patients and families in crisis or when experiencing loss. In a birth center, however, the emphasis is on promoting a healthy, normal birth process. Many nurses choose this setting because they enjoy supporting and caring for laboring/birthing women, their newborns and their families that are receiving a new member. The death of a newborn or its mother is a human tragedy; families anticipate taking home a healthy newborn after a good, safe delivery, and they grieve intensely when the outcome involves loss. It can be particularly difficult for perinatal nurses to cope with loss (Beck & Gable, 2012; Dietz, 2009; Puia, Lewis, & Beck, 2013). Birth is not an illness process, but rather a normal event occurring thousands of times every day around the world. We recognize that emergencies occur, and families depend on us to intervene in such cases. Perinatal nurses train for emergencies, with, among other things, training in cardiopulmonary resuscitation, neonatal resuscitation and advance cardiac life support for obstetrics, along with a myriad of simulations and drills. In short, we are prepared.

Abstract The work of perinatal nurses sometimes includes emergencies involving death, or near death, which can leave health care providers with feelings of stress and grief. After experiencing a particularly stressful period, nurses at our organization identified processes to help themselves recover and to support each other. The result of this work is a written plan to facilitate the support of perinatal nurses after critical events. This article describes the development and implementation of this plan. DOI: 10.1111/1751-486X.12094

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But who cares for health care providers when unexpected tragedies occur? This article describes how a plan was developed and implemented to help perinatal nurses cope with the stress of critical events and death.

The Challenge

Our facility is a hospital-based, level one family birth center with 23 labor-delivery-recovery-postpartum rooms where we provide family-centered care. We designed this unit from a more traditional setting more than 20 years ago and cross-trained all the staff to be perinatal nurses, caring for women and newborns in all phases of childbearing with the benefit of shared skills, and with a nurturing environment for our families and each other.

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In one recent 4-month period we had an unusual number of emergencies, including massive transfusion codes, a ruptured uterus of a primigravida during a vaginal delivery, several placental abruptions, unexpected vaso-previas and the sad loss of more than one newborn. One of our massive transfusion codes was for a woman having a normal, repeat cesarean surgical delivery who developed disseminated intravascular coagulation and required more than 100 units of blood products.

The nurses became quite skilled at emergency cesarean deliveries, neonatal transfusion, adult massive transfusion protocol, transferring patients to higher levels of care and supporting families with loss. The signs of stress became apparent as nurses commented about their fatigue, grief and anxiety about assignments that might bring higher risk.

The recommended routine after such emergencies is to invite all participants, including physicians and nurses, to a debrief meeting within a week (Dietz, 2009). In our department, a clinical nurse educator leads the clinical debriefing session, which is designed to review the woman's record and sequential description of events by health care providers. The objective is to see what went well and to identify opportunities for improvement. The staff looks forward to this event, but by design it doesn't address immediate emotional needs of staff (Dietz, 2009). Staff identified a need to debrief in the immediate time frame before leaving the hospital when a significant event had occurred.

Developing the Tool

A small process improvement team was formed to address staff concerns. An e-mail was sent to all nurses, inviting them to participate in developing a plan to help staff cope with emergencies. It was important that all stakeholders and management be involved. The chaplain's office, social services and the nurse manager were invited. Ultimately the team included three to four nurses from each shift, a chaplain, the social service coordinator assigned to our floor and our supervisor. We planned a meeting to look at the issues and possible solutions.

The meeting started with an opportunity to express personal experiences and define desired goals. Several nurses shared tears while recounting events, describing how challenged they felt and verbalizing feelings of being overwhelmed and unacknowledged at the end of the event. Many felt it was difficult to return to work, and expressed need for time to recover and do self-care. Team members also expressed concerns about their assigned patient load while assisting in the emergency; they needed reassurance that other staff members had covered their assignments. Finally, we narrowed down what we hoped to achieve in caring for each other, and the events that would trigger implementation of our plan.

Addressing Stressors

The most common characteristics that nurses found most stressful were as follows: (1) the events were unexpected, (2) events required additional resources from outside the department, (3) patients required transfer to a higher level of care, such as ICU or transport to a NICU. In addition, nurses expressed concern about the care of the patients that each was responsible for, and the need to know that someone else had been assigned to care for them. The patients had always been cared for,

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