

UNRECOGNIZED LOSS:
HOW TO BEST SUPPORT WOMEN EXPERIENCING MISCARRIAGE

By

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Abstract

Miscarriage, or early pregnancy loss, is a fairly common occurrence in the United States, with approximately 11-41% of women experiencing at least one lost pregnancy during her lifetime. Yet, despite the prevalence of miscarriage, women report dissatisfaction with the quality of care they received from their healthcare providers. The purpose of this thesis is to identify deficiencies of care in the treatment of women experiencing miscarriage and to establish evidence-based recommendations to promote quality patient care and improve patient satisfaction. Research was collected and synthesized from the CINAHL and Medline/PubMed databases. Studies show that women want providers to address their emotional needs, not just their physical needs. They want providers to fully explain the process of miscarriage and their treatment options in understandable language rather than medical jargon. Above all, they want to feel that their pregnancy loss is being recognized as a significant or even traumatic event. This thesis includes best practices recommendations and a theoretical protocol to assist healthcare providers to improve their care of this patient population.

Chapter One: Introduction

Miscarriage is a fairly common occurrence in the United States, yet many women report dissatisfaction with the quality of care they received from their healthcare providers. Nursing schools only briefly touch on miscarriage as a loss that women experience, and many healthcare workers report receiving no training on how best to treat a patient suffering through miscarriage. This thesis seeks to identify existing deficiencies in care through review of relevant medical literature and to develop evidence-based best practice recommendations for treating women experiencing miscarriage. Specifically, this thesis will explore which nursing interventions in the hospital setting are most effective in providing holistic care to women experiencing the loss of a child before 20 weeks gestation.

The first chapter of this thesis will provide an overview of the terminology and issues commonly encountered in treating patients experiencing miscarriage.

Miscarriage

According to the World Health Organization, miscarriage is defined as the loss of a pregnancy due to the expulsion or death of a fetus or embryo weighing less than 500 grams before the 20-24-week gestation mark (Agenor & Bhattacharya, 2015). The prevalence of this problem varies widely in the literature on the subject, with reports declaring that 11% to 41% of women have experienced early pregnancy loss during their lifetime (Agenor & Bhattacharya, 2015). Chromosomal abnormalities account for approximately 50% of miscarriages (Feodor Nilsson, Anderson, Strandberg-Larsen, & Nybo Anderson, 2014). Other potential risk factors that can increase a woman's chance of having a miscarriage include alcohol and caffeine consumption and smoking (Feodor Nilsson et al., 2014). Miscarriage is sometimes referred to as

a “spontaneous abortion,” which is the medical term for the condition, but because of the negative connotations of the word “abortion,” it is being used less often (Agenor & Bhattacharya, 2015). More common terms used include “early fetal demise” or “early pregnancy loss” (Agenor & Bhattacharya, 2015).

Miscarriage can be further broken down into one of four categories: “threatened,” “inevitable,” “incomplete,” or “missed” (Limbo, Glasser, & Sundaram, 2014). Inevitable miscarriage is the primary focus of this paper. Symptoms that a woman may experience that indicate an inevitable, or unavoidable, miscarriage are bleeding, cramping, absence of the usual signs of pregnancy, absence of fetal heartbeat, and absence of fetal tissue on sonogram (Limbo, Glasser, & Sundaram, 2014). Approximately 1-3% of women suffer from recurrent miscarriage, which is defined as three or more consecutive losses prior to 24 weeks gestation (Agenor & Bhattacharya, 2015).

Women who experience miscarriage can experience a wide variety of emotional responses, including feelings of guilt, grief, or being cheated out of motherhood, though there are some cases where women see miscarriage as a positive occurrence (Limbo, Glasser, & Sundaram, 2014). The degree of “personhood” that the parents attribute to the fetus can have a significant effect on their emotional reaction to the news of the miscarriage (Limbo, Glasser, & Sundaram, 2014). Other factors that affect a woman’s emotional response to miscarriage include how long the pregnancy lasted, the woman’s history of miscarriage or infertility, and the number of children that the woman already has (Huffman, Schwartz, & Swanson, 2015).

Treatment Options

When a woman is diagnosed with an inevitable miscarriage, she is presented with three treatment options: uterine aspiration (surgical removal), medical management, or expectant

management (Schreiber et al., 2016). Surgical treatment involves fasting, curettage under general anesthesia, and 2-4 hours of observation in the hospital afterwards, with no follow-up needed after the procedure (Olesen, Graungaard, & Husted, 2015). Medical treatment involves 4 hours of observation at the hospital and the prescription of a drug called misoprostol (Olesen et al., 2015). Misoprostol can be taken anywhere, and often the woman chooses to take the pill and have the abortion at home, with a follow-up at the hospital after one week to ensure that all of the tissue has been removed (Olesen et al., 2015). Expectant management involves no treatment at all, simply waiting for the miscarriage to occur on its own; this requires follow-up after one week as well (Olesen et al., 2015). Many factors affect a woman's choice of treatment options, which are explored in more detail in chapter two of this thesis.

Significance to Nursing

Any nurse who works with women will sooner or later encounter a woman who is currently experiencing a miscarriage or has done so in the past. This is even more true for nurses who work in emergency departments because most women who experience the significant bleeding associated with miscarriage will go to the emergency department for help. Nurses need to handle the immediate effects of the women discovering their miscarriage and be able to care for their patients appropriately and sensitively. Although all healthcare providers should be aware of the physical and emotional aspects of miscarriage, nurses encounter patients more than any other type healthcare provider, so it is crucial that they are equipped with the knowledge and skills needed to properly care for this specific population (McLean & Flynn, 2013).

Conclusion

Although miscarriages are prevalent, research shows that there are no established standards of care for working with and treating women who are suffering from miscarriage

(Geller, Psaros, & Kornfield, 2010). Women often report frustration with the lack of empathy from their providers, which is evidenced by the use of medical jargon, suggestions to “try again,” long wait times, limited privacy, and failure to discuss the meaning of the loss (Engel & Rempel, 2016). Because miscarriages can have an immense emotional impact on a woman and her family, it is vital that nurses in particular, understand how women respond to miscarriage and become aware of the types of services that they can offer to help their patients during this difficult time.

Chapter Two: Review of Literature

The PICOT question used to guide the research is: What nursing interventions in the hospital setting are most effective in providing holistic care to women who are experiencing or have experienced miscarriage? The articles included in this review fall under three main themes: the experience of miscarriage for women, the importance of choice and factors affecting choice of treatment methods, and identification of ways that healthcare providers, including nurses, can improve their care of patients in this population. Articles were found using the CINAHL and Medline/PubMed databases. Key words such as “spontaneous,” “abortion,” “miscarriage,” “nursing care,” “treatment,” “psychology,” “interventions,” and “healthcare” were used to locate relevant literature. Articles that focused on women who experienced loss after the 20 week gestation mark were not included in this review. A total of twelve articles are included, which can be broken down into 5 qualitative studies, 3 quantitative studies, 3 systematic reviews, and 1 mixed-method study. All articles were published between 2010 and 2016. A Table of Evidence of all of the research included in this review is located in Appendix A.

The Experience of Miscarriage

Although often downplayed, miscarriages are as significant as any other type of loss, and many patients feel devastated by the experience. The following articles focus on the experiences of women suffering miscarriage.

Emotional Distress

Radford and Hughes (2015) conducted a systematic review to understand women’s experience of miscarriage prior to 16 weeks gestation by identifying themes from studies published since 1990. The sample included 9 papers which documented 211 individual experiences. The papers were collected from PsychInfo, CINAHL, British Nursing Index, and

Medline. They found 22 papers relevant to their topic, but after applying specific inclusion and exclusion criteria, 9 papers were selected for analysis. They appraised each study with the Critical Appraisal Skills Programme. Five of the papers included used purposive sampling. A table of findings was used to present the findings and samples of the studies included.

Findings from this systematic review revealed that women needed to feel that their emotional distress and physical symptoms were being recognized by their families and healthcare providers (Radford & Hughes, 2015). Most women reported feeling isolated, lonely, distressed, shocked, and grief-stricken. Some women felt a loss of identity through the miscarriage process: all lost the identity of being a mother, and some even lost the identity of being a woman. According to the study, emotions play a key role in women's perceptions of the care they receive. The most significant finding that pertains to the nursing practice was that women reported wanting more interaction with nurses on an emotional level. The women emphasized the importance of empathy, sympathy, and reassurance from nurses as helpful in their ability to cope and in their long-term recovery (Radford & Hughes, 2015). This review effectively provide insight into how women perceived their miscarriage and the kind of care they wanted.

The results of the Radford & Hughes study were validated in several ways. Member checks were used to confirm codes and subthemes found from the studies. The methods were appropriate for the study. The review came from a peer-reviewed journal. The authors validated the studies included in the review with an established measurement of appraisal, and weaknesses were noted. The papers included in the review came from different countries, so the review provided a slightly global perspective on the experience of miscarriage. However, the articles had a few weaknesses. The articles were mostly from westernized countries, the methodologies

of the studies included were not clearly stated, and no quotes from the original articles were set forth to back up the subthemes established by the authors.

Attempting to Cope

Nikcevic and Nicolaidis (2014) conducted a randomized control trial longitudinal study designed to analyze how “finding meaning” helped women cope with their miscarriage. The study included 127 women randomly assigned into an intervention group (IG, N=66) or a control group (CG, N=61). The intervention group was further randomized into two other groups: women who received further psychological counseling after medical counseling (placed in the MPC group, n=33) and women who did not receive further counseling, placed in the medical-counseling-only group (MC, n=33). The women in the control group received no specific counseling post-miscarriage. Psychological outcomes were assessed at 4, 7, and 16 weeks after diagnosis with the use of questionnaires. All participants received surgical evacuations, and over 90% of the participants were white. Women with recurring miscarriages and those under psychological or psychiatric care were excluded from the study.

The study found that by week 7, significantly more women in the IG had found understanding and meaning in their miscarriage when compared to the CG. Those who reached an understanding of their loss thought about the cause of the loss less often and felt less distressed than those who did not have that understanding (Nikcevic & Nicolaidis, 2014). Although the findings were not specifically geared towards the nursing practice, nurses can certainly assist women in finding meaning in their miscarriages by practicing effective therapeutic communication.

The longitudinal study design was appropriate for the study. Specific inclusion and exclusion criteria were noted, and true drop-out rate was recognized and explained. The scale

that was used to measure the women's anxiety and depression, HADS, was validated with a previous study that was cited. Chi-squared analysis was used to establish baseline differences between the groups. Interpretation of the results was validated by detailed statistics, and statistical significance was established. The study compared itself to similar studies, and the findings were concurrent. The study was limited by its lack of diversity: the sample was mostly white older women of higher socioeconomic status in stable relationships with planned pregnancies. The generalizability was also limited by the use of convenience sampling. The extraneous variable of time could possibly have had some effects that discredit the findings. Although the authors reported there were no statistical differences between the groups, 80% of the IG group already had children, whereas only 56% of the CG group had children (Nikcevic & Nicolaides, 2014). This could be a possible explanation as to why the IG group had an easier time coping than the CG group.

Grief

Huffman, Schwartz, and Swanson (2015) conducted a descriptive cross-sectional comparative study to explore the effects of gender, age, mental health history, and reproductive factors on couples' responses to miscarriage. The impact of miscarriage was measured by the Revised Impact of Miscarriage Scale (RIMS), and data was retrieved secondarily from the Couples Miscarriage Healing Project (CMHP), which was a Randomized Controlled clinical trial assessing the effects of three theory-based interventions on grief and depression experienced by patients in the first year after miscarriage (Huffman et al., 2015). This Secondary Analysis was approved by the University of North Carolina at Chapel Hill Institutional Review Board. The scale that was used to measure grief, isolation, and devastation after miscarriage was validated in a previous study that was cited by the authors. The total sample included 341 couples who had

experienced miscarriage approximately 3 months prior to the original study conducted by CMHP. The large sample contributes to the generalizability of the study; however, a majority of those who participated in the study were middle class, college-educated, heterosexual couples.

Multifactorial analysis of variance was used to test for significant differences in grief and depression based on gender, age, mental health history, infertility, number of living children, number of prior miscarriages, and gestational age (Huffman et al., 2015). The authors discovered that the women who were studied experienced a much greater impact than their male partners (Huffman et al., 2015). However, the authors also recognized that the RIMS score may not be the most appropriate index for measuring the male experience of miscarriage, so the impact to the male partners may have been underestimated. The authors found that age was a more significant predictive factor of grief and isolation than history of mental health issues; younger couples who had a history of mental illness were more likely to experience grief than their counterparts with no history of mental illness, whereas grief in older couples did not vary based on history of mental health status. The study found that couples experience less grief when the miscarriage occurred at less than 8 weeks gestation compared to a later gestational age, which may be due to less opportunity to form attachments and dreams of the future (Huffman et al., 2015). The authors found that couples with a history of infertility were more likely to experience higher levels of devastation, grief, and isolation than those without such history. Miscarriage history also significantly increased feelings of isolation, grief, and devastation (Huffman et al., 2015). Couples with no children experienced more grief than couples with one child. Surprisingly, couples with two or more children suffered similarly to the couples who had no children (Huffman et al., 2015). Thus, having one child was protective against the grief of miscarriage, but having more than one child was not. The authors attributed this finding to the possibility that

families with more than two children are purposely trying to extend their family, and this is why they feel similar devastation to those who have no children at all (Huffman et al., 2015). These findings can provide nurses with insight into which factors can put someone at greater risk at experiencing grief, isolation, and devastation, which can guide them in knowing which interventions may be most appropriate for that subset of patients.

The Importance of Choice

The ability to choose how the pregnancy ends is extremely important to the women experiencing inevitable miscarriage. The following articles focus on why this aspect of care is so important.

Factors that Influence Treatment Choices

Olesen, Graungaard, and Husted (2015) conducted a qualitative, grounded theory study to learn more about how women who experience miscarriage make decisions about their treatment. The study consisted of 11 qualitative, semi-structured interviews with six women 30 to 41 years old and five healthcare providers working in an emergency gynecological department. Women were informed about their options for treatment and typically chose to be treated the same day or the day after. The interview process began 14 days after treatment. Women with unwanted pregnancies were not included in the study.

The main finding of this study was the theme of “unspoken emotional considerations that guided the decision-making process”. Women kept their reasons to themselves, and the healthcare providers did not explore their reasoning during the pretreatment counseling. The study found that women who chose the surgical intervention did so because they were afraid of seeing and aborting the fetus at home, while women who chose the medical treatment were afraid of the anesthesia; yet the healthcare providers erroneously assumed that women chose

their treatment plans based on biomedical considerations (Olesen, Graungaard, & Husted, 2015). In other words, providers were under the misconception that women chose treatment options based on the physical pros and cons of each option, not taking into account any possible emotional considerations. The authors found that women were unhappy that their feelings were not addressed in the pretreatment counseling, although they were appreciative that they were given a choice on their course of treatment. In regard to nursing practice, nurses reported that many of the women that they provided care to did not get adequate education from their providers. Many of the women who chose the medical treatment option would call to have information repeated that had previously been misunderstood or forgotten. These women were surprised about the severity of their symptoms because they were not adequately educated while at the hospital. These findings emphasize the importance of nurses assisting in patient teaching. Patients should have all of their questions answered prior to leaving the hospital, and it is important for providers to give patients an accurate picture of the things they are likely to experience. Written explanations may also be helpful, because during emotional times, absorbing information may be more difficult.

The method of the study was appropriate for the purpose, and data was saturated after the 11 interviews. Constant comparison analysis was used to revise the interview questions as the interviews went on (Olesen et al., 2015). The procedure for identifying themes was detailed. Ample quotations were used to back up the themes determined by the authors. The study did not report information about the demographics of the sample, only mentioning the age of the women participating and the number of children they already had. No information was given about the healthcare provider demographics. Although data saturation was achieved, the sample size was small, even smaller when split between women and healthcare providers. Most of the women

were older, which can limit generalization. The study cautions that the findings would not be transferable to other ethnic backgrounds, mentioning the lack of diversity included in the sample. The lack of diversity cannot be determined by the reader because the study did not note the racial and ethnic characteristics of the group.

Schreiber, Chaves, Whittaker, Ratcliffe, Easley, and Barg (2016) conducted a mixed-methods study to identify factors that are prioritized by patients and doctors during the management of first-trimester miscarriage and to assess what makes patients satisfied with their care. Participants were recruited with purposive sampling from the Hospital of the University of Pennsylvania. All participants were clinically stable women who sought treatment due to specific symptoms (bleeding or cramping), who had a diagnosis of fetal demise via ultrasound prior to 12 completed weeks of gestation, and who spoke English (Schreiber et al., 2016). Participants filled out demographic and psychosocial surveys. The psychosocial surveys included the Center for Epidemiologic Studies Depression Scale, the Beck Anxiety Inventory, the Perceived Stress Scale, the Posttraumatic Stress Disorder Checklist—Civilian, and the Social Support Interview, all which were validated by previous studies cited by the authors. After the completion of these surveys, semi-structured interviews were conducted with 45 of the original 55 participants. It was not necessary to interview all 55 because data saturation was reached (Schreiber et al., 2016).

Approximately 55% of the women stated that their first choice of treatment was surgery, 33% said their first choice was medical management, and 13% said their first choice was expectant management (Schreiber et al., 2016). After counseling from healthcare professionals, 62% of participants chose the surgical intervention, 35% chose the medical management, and only 4% (two participants) chose expectant management (Schreiber et al., 2016). The

demographic analysis revealed that women who chose surgical management were statistically more likely to have education beyond high school and to earn more money, and less likely to report being depressed (Schreiber et al., 2016).

The women of the study reported in their interviews that it was essential for them to feel in control and to be able to predict when and where they would have their miscarriage (Schreiber et al., 2016). Some women who chose surgical management reported doing so because they did not want to miscarry at work, and some chose it because they did not like the sight of blood. Some were concerned about the risk of incomplete abortion, which is associated with medical or expectant management (Schreiber et al., 2016). Some women who chose medical management reported doing so because surgical treatment felt too much like an elective abortion (Schreiber et al., 2016). Some women reported wanting to start trying again for another baby right away, so they did not want to wait for the miscarriage to happen naturally. The 18% of women who changed their minds about their treatment path after medical counseling reported that their decision was influenced by their healthcare provider, their family and friends, and their desire to avoid the uncertainty of waiting for the miscarriage to occur on its own (Schreiber et al., 2016). Regardless of the type of management chosen, the women's level of satisfaction with their treatment depended on the presence of supportive and compassionate staff, receiving sufficient information about their treatment options, and their confidence in the quality of care they received (Schreiber et al., 2016).

The study was strengthened by its data saturation and mixed analysis. Logistic regression, confidence intervals, and odds ratios were used to determine statistical significance in the quantitative data. Qualitative data was coded by line-by-line reading of the interview transcripts, and ample quotes were supplied to justify the themes that were chosen. Although the sample size

was small, the sample was diverse. However, the study was limited by the fact that all the participants were recruited from a single institution, and all participants were English-speaking.

Confidence in Diagnosis and Treatment Choice

Limbo, Glasser, and Sundaram (2015) conducted a qualitative study to understand women's decision-making process after learning that miscarriage is inevitable. Women were interviewed via 30 to 45-minute phone calls. A total of 23 women were included in the study, all well-educated with a mean annual income between \$50,000 and \$70,000. Of the 23 women, 15 chose surgical interventions (suction curettage), seven chose expectant management, and only one chose the medical intervention (pills inserted into the vagina).

The main finding was the theme of "being sure," which is broken down into two categories: 1) being sure of the diagnosis and 2) being sure of the treatment options. Women reported that the things that helped them feel sure of the diagnosis were their own intuition, physical symptoms, and ultrasound confirmation. However, it is important to note that their experiences varied greatly; some women only needed one ultrasound to be sure of the diagnosis, whereas one woman had three ultrasounds and was still not completely certain she had miscarried (Limbo, Glasser, & Sundaram, 2015). When deciding on treatment options, several women voiced concern over having a procedure that could be misunderstood as an elective abortion. For them it was extremely important to know that they really did miscarry and were not ending a viable pregnancy. The study findings are relevant to the education component of the nursing practice. Nurses can inform women about the symptoms they are likely to experience. They can ask open-ended questions that may help women express what information they need to feel more sure about their diagnosis or their treatment choice.

A major strength of this study was the use of constant comparison analysis to update interview questions as the interview process progressed. The study quoted some of the questions asked, and they were clearly unbiased and open-ended. Inclusion and exclusion criteria were noted, purposive sampling was used, and data was saturated. There were ample direct quotes from the participants that validated the themes and subthemes. The study listed implications for nursing practice, and even included examples of questions that nurses could ask patients to help them feel more secure in their decisions. The biggest weakness of this study was that it did not recognize its own limitations. Based on the convenience sampling, the results are limited in their ability to be generalized to the whole population.

Improvements in Care

Many recent studies have found deficiencies in the treatment that is offered to patients who are suffering from miscarriage. The following articles detail ways that healthcare providers can improve patient outcomes and overall satisfaction with their care.

Deficiencies in Current Care

Engel and Rempel (2016) conducted a mixed-methods study to understand the relationship between healthcare providers' attitudes about miscarriage and how those attitudes affect care. The survey was electronically distributed to 174 providers, including 50 physicians, 63 RNs, 38 midwives, 9 nurse practitioners, and 4 others. Nurses in emergency departments were recruited through three different hospitals, two urban and one rural. The average number of women treated by the providers in the previous 12 months was 19, but ranged from 0 to 234 women. An expert panel of three RNs with experience in perinatal loss evaluated the questionnaire for validity and clarity of questions. The providers' beliefs were measured on a

Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). There were also a few free response questions.

Responses from providers were fairly divided about whether miscarriage was a normal event. Opinions also diverged as to whether women should just “move on with their lives”, with 47% disagreeing with the statement and 38% agreeing with it (Engel & Rempel, 2016). Several providers agreed that the emergency department was not a good place for a woman to lose a baby because of rapid turnover, pace, busyness, lack of privacy, and limited time to interact with staff. Forty-three percent of the providers indicated that there were no established policies regarding miscarriage in their area of practice, with 21% unsure if the policies existed at all. One of the key findings of the study was that the more experienced healthcare providers offered less information and support to the women suffering miscarriage. This implies that the more providers work with miscarriage patients, the more normalized the experience becomes, and the less individualized the care becomes. In regard to nursing care, there were two very concerning findings. Registered nurses were the least likely to mobilize support and provide information to mothers, and only 6% claimed to feel prepared to provide support (Engel & Rempel, 2016).

A major strength of this study is that the findings of this study are consistent with other similar studies. Exploratory factor analysis with Varimax rotation was used, which is a strength of the article, for it further validates the conclusions. There were adequate tables, and several quotes from the free response section to back up the findings of the study. Multiple regression analysis was also used. The study had great insight regarding the importance of role confidence and of education in mobilizing support. The only clear weakness was the study’s use of convenience sampling. It also failed to indicate how long the providers had been working in their fields, which could affect how comfortable they were with working with this population.

Gergett and Gillen (2014) conducted a qualitative study to explore the perceptions of professionals caring for families who have experienced miscarriage. Purposive sampling was used from one health and social care (HSC) trust in Northern Ireland. Participants were given two options to choose from, depending on their preference and availability: to participate in one-on-one interviews, or to participate in a focus group (Gergett & Gillen, 2014). Altogether, 39 professionals from several areas participated in seven focus groups and 10 one-on-one interviews. The questions given to participants were pilot-tested with three participants by three healthcare professionals who had experience caring for families experiencing miscarriage; these interviews were used to validate the accuracy of the questions but were not included in the final study. The transcripts from the focus groups and the individual interviews were transcribed, and samples of the transcripts were sent to the participants for review of the themes that were drawn to validate them, which strengthens the findings of the study (Gergett & Gillen, 2014). As a theoretical framework, the study used Swanson's Theory of Caring, which is made of five processes: knowing, being with, doing for, enabling, and maintaining belief (Gergett & Gillen, 2014). Several citations establishing the validity of the theory were included.

Under the "knowing" process, the theme of "different gradients of loss" emerged (Gergett & Gillen, 2014). Providers admitted that they tended to be less sympathetic toward women experiencing miscarriage than they were toward women who suffered from a stillbirth or neonatal death (Gergett & Gillen, 2014). Some providers also mentioned that they became numb to the loss because they frequently treated women experiencing miscarriage. Some providers admitted that the further along the pregnancy was, the more the fetus looked like a baby, and the more the miscarriage affected them (Gergett & Gillen, 2014). Finally, some participants

mentioned the difficulty they faced in feeling sympathetic for women who had ectopic pregnancies because it was a potentially life-threatening situation.

Under the “being with” aspect, the theme of “the need for time” was prominent (Gergett & Gillen, 2014). Providers mentioned the difficulty in finding time to discuss the emotional impact of the loss with women in a busy work environment. They also mentioned that it can take time for women to process the information being given to them, which can make it difficult to determine the right time to talk about options and how they feel about their condition. Providers admitted that it was difficult to be confident when speaking to this population because of the wide variety of reactions that women may have to the news of miscarriage (Gergett & Gillen, 2014). The providers also believed that they were not given adequate training in how to counsel these patients, and that they were afraid of saying the wrong thing. Finally, they mentioned the difficulty working with women who do not speak the same language as they do. Time delays in acquiring an interpreter in emergent situations can decrease the provider’s ability to give compassionate care to their patients (Gergett & Gillen, 2014).

Under “doing for”, the main theme was “physical aspects of care” (Gergett & Gillen, 2014). Although the providers were from different disciplines, all of them agreed that the physical wellbeing of the woman took precedence over her emotional wellbeing, at least during the initial stages of care (Gergett & Gillen, 2014).

Under “enabling”, the main themes were “creating memories” and “terminology” (Gergett & Gillen, 2014). Providers, especially midwives and nursing staff, mentioned the importance of giving the baby an identity and giving the parents some sort of memento that recognized the miscarriage as the loss of a baby (Gergett & Gillen, 2014). Less experienced providers felt that this was one of the most difficult aspects of caring for these women; they were

concerned over recognizing the baby in the correct manner, and they were unsure how to handle the fetal tissue. Providers also mentioned difficulty in deciding what level of terminology was best. Some providers recognized that women could find medical terminology insensitive during this delicate time, whereas others felt that the use of medical terminology could help reduce emotional overload (Gergett & Gillen, 2014).

Finally, under the “maintaining belief” were the themes “follow-up” and “impact on future pregnancies” (Gergett & Gillen, 2014). Some providers questioned how realistic it is to expect every woman who experiences miscarriage to get follow-up care, given that miscarriage is a common occurrence. The providers mentioned that it may be better just to offer counseling, recognizing that not all women want or need counseling (Gergett & Gillen, 2014). Regarding future pregnancies, participants recognized that the proper handling of miscarriage treatment can have positive effects.

Some recurring themes that did not fall under any of the broad theories included the benefits of preparing information pamphlets and the need for more specific training in working with the patient population (Gergett & Gillen, 2014).

The study does not explicitly list its limitations. Because the sample came from only one institution, its generalizability may be limited; this is one weakness of the article.

McLean and Flynn (2013) conducted a qualitative exploratory study regarding the experience of women attending a hospital for miscarriage in the first 20 weeks of pregnancy. The study had only six participants after exclusion/inclusion criteria were applied, but even though this sample size is extremely small, the women all received treatment from different hospitals, so the results may be more representative of current practices than one might assume. It is important to note that the sample size was not small because data saturation was achieved, but because only

12 women responded, and only six fit the criteria (McLean & Flynn, 2013). Four of the women experienced more than one miscarriage, and all four went to the same hospital for treatment for both miscarriages. Thematic analysis was used on the data collected from the interviews. Three main themes emerged: “medical management,” “compassion,” and “a consistent and specialized response” (McLean & Flynn, 2013).

The study discovered that treatment response varied greatly from institution to institution; the only consistent factor was that at some point the women met medical staff, either an obstetrician or an ED doctor (McLean & Flynn, 2013). Participants reported that nurses were the most frequently encountered type of healthcare provider. Even though the patients all presented with the same symptoms, the treatment paths were inconsistent. One woman mentioned that her doctor made ten attempts to correctly place the speculum, which decreased her confidence in his abilities to care for her (McLean & Flynn, 2013). Another woman mentioned that upon discharge, her doctor wrote “vaginal bleeding” as the reason for her absence from work, which she felt did not accurately represent why she was in the hospital. Overall, the women felt that the care they received was disorganized.

The patients’ consensus for compassionate care included three components: being seen by providers promptly, being given clear information about the miscarriage, and being recognized as suffering a loss. Four of the women felt that the hospital staff disregarded their ability to know their own bodies (McLean & Flynn, 2013). All six women described not receiving any handouts or pamphlets about miscarriage or adequate information from the doctors about what to expect physically when the miscarriage occurs and the emotional consequences of the loss. One woman reported having to use Google to supplement the information she was given

because she did not feel she had a full understanding of her miscarriage (McLean & Flynn, 2013).

Finally, the participants reported wanting a more consistent and specialized response (McLean & Flynn, 2013). One participant suggested having someone ask the patient how she was feeling upon admission, just so the patient feels that the team is immediately invested in her emotional care as well as her physical care. Although the quality of evidence from this study may not be very high, it is still useful in conjunction with the other similar studies presented in this review.

The major weakness of this study lies in its extremely small sample size. However, the results are consistent with other similar research articles, which strengthens the findings.

Geller, Psaros, and Kornfield (2010) conducted a systematic review to explore the satisfaction of women who receive “typical” health services following early pregnancy loss. The review included 16 studies, all collected from PubMed, PsychInfo, and CINAHL. There were four main themes that the authors found in the research: attitudes of healthcare providers, provision of information, interventions provided, and follow-up care (Geller, Psaros, & Kornfield, 2010). The total sample size included in the 16 articles was more than 1700 participants, including women, their significant others, and healthcare providers. A detailed table of findings was included in the review.

One of the articles included in the study found that between 26% and 35% of women interviewed were “fairly dissatisfied” or “very dissatisfied” with the care or information they were given (Geller et al., 2010). In other words, a total of 61% of women were unhappy with the care that they received, a staggering number. One woman remarked that her dissatisfaction stemmed from the clear discrepancy between her valuation of her loss and her provider’s

apparent valuation (Geller et al., 2010). Another study found that 79% of the 24 women interviewed were never asked about their feelings throughout the medical interaction. Those who were satisfied with their care reported having a caring relationship with their providers.

Another study reported that even though most of the participants were provided with information on their miscarriage, about half of the women felt that the information was not sufficient (Geller et al., 2010). Some women mentioned the lack of practical information, such as how much bleeding to expect, when to expect regular menstrual periods to return, and what the implications were for future pregnancies. One study found that only 38% of participants felt that they were “definitely” given enough information about their miscarriage, and only 28% felt that they were “definitely” given enough information regarding future pregnancies (Geller et al., 2010). Some women reported being dissatisfied because they did not feel that they were given an adequate explanation as to why the miscarriage occurred. Vague explanations and medical jargon were often not appreciated by patients (Geller et al., 2010).

One study found that the more interventions that are conducted, the more satisfied women are with their care, although this correlation did not continue with follow-up care (Geller et al., 2010). Women reported needing education on what caused the miscarriage, wanting laboratory tests to determine potential causes for the loss, and desiring to see the fetus after it was removed. Another study found that one of the most common complaints of women experiencing miscarriage was that they were often treated on the labor and delivery or maternity floors, where they would have to hear the cries of babies from down the halls, which only intensified their grief (Geller et al., 2010).

One study included in the review reported 52% of participants were dissatisfied with their follow-up care, while another found that 64% of participants experienced guilt after miscarriage,

and that talking about the loss to someone was helpful in feeling reassured that their actions did not cause the miscarriage (Geller et al., 2010).

The systematic review was strong in recognizing the individual flaws of each of the included articles, in highlighting their strengths, and in explaining why the information was significant.

What Women Want from Providers

Robinson (2014) conducted a systematic review to determine the importance of information and support to women who have experienced an early miscarriage. The review contained four qualitative studies and one quantitative study. The studies were collected from CINAHL, Medline, PsychInfo, Amed, and Ovid. The key words used in the search were: miscarriage, abortion, spontaneous, early pregnancy loss and patient information, patient education, communication, follow-up and aftercare.

The main findings of the study were divided into four categories: physical, psychological, information, and support. Women felt that there was not enough information given to them about the physical aspects of their miscarriages (Robinson, 2014). They reported that they felt unprepared and that their symptoms were worse than they anticipated them to be. The review found that 95% of women who responded to one study reported that some sort of post-miscarriage support was necessary and that the existing interventions were not adequate. Many women expressed frustration over the use of medical terminology and insensitive comments, which added to their lack of understanding (Robinson, 2014). According to the review, ceremonies and rituals positively affected the women's ability to come to terms with their loss.

The strength of Robinson's paper lies in his detailed review of the studies selected and detailed table of findings. The mixture of both quantitative and qualitative studies contributes to

the strength of his findings. Robinson recognizes the weaknesses in the studies included, as well as deficits in the research. However, he includes very few studies, and his exclusion criteria are not listed.

Benefits of Follow-Up Care

Johnson and Langford (2015) conducted a randomized control study to determine if women who experienced an immediate bereavement intervention in the hospital experienced less grief at the 2-week follow-up than those who did not. The study included 40 women, mostly of Hispanic descent, between the ages of 18 and 42 years old. The average annual income was less than \$21,000 a year, and most did not have health insurance. The study took place in an obstetric emergency center (OBEC) in the south central United States. Women were randomly assigned to either the treatment group or the control group, and there were no significant demographic differences between the two groups. The treatment group received a 1-hour bereavement intervention based on *Guidelines for Medical Professionals Providing Care to the Family Experiencing Perinatal Loss, Neonatal Death, SIDS or other Infant Death*. The control group received routine care, which focused mostly on the management of physical symptoms. At the 2-week mark, the Perinatal Grief Scale was used. No pretest was used to establish a baseline.

The study found that the women in the treatment group reported lower levels of overall grief than the control group, although both did report moderate levels of grief. Despair levels were 50% less for women in the treatment group (Johnson & Langford, 2015). The results also indicated that grief experienced by women after miscarriage is similar to the grief of women who experienced loss at later periods of gestation.

The study contains a detailed literature review, including both positive and negative outcomes. Inclusion and exclusion criteria were clearly stated, and the scale that was used to

measure grief was cited. Cronbach alpha coefficients were used for the scale to further establish validity (Johnson & Langford, 2015). A power analysis was used to determine sample size. Chi-square and t tests were used to check for significant differences between the groups. Overall, this study filled a gap in the research; most other studies on this subject matter include mostly white, well-educated, upper-class women, whereas this study had a greater minority population with lower education and income. The study's greatest weakness was the posttest-only design. Without a pretest to establish a baseline, there is no way to tell whether the findings were due to the intervention. Further, the sample size was small, and the lack of follow-up over time limits any conclusion about the effectiveness of the intervention over the long term.

Conclusion

Overall, it is clear that miscarriage is a significant event in a woman's life, and that it is crucial for healthcare providers to recognize the importance of the loss in order to provide the highest level of care. Giving patients adequate information, showing compassion, treating them promptly and respectfully, and clearly explaining their options were all practices that contributed to patients' satisfaction with their care. Women disliked the use of medical jargon, and felt that it devalued the patient-provider experience. Pamphlets and effective follow-up care options helped women cope with and understand their loss. Having an adequate understanding of the loss was seen as important to healing, especially in promoting reassurance that miscarriages often occur through no fault of the woman.

Chapter Three: Best Practice Recommendations

The articles discussed in chapter two draw attention to many instances in which the care provided to women experiencing miscarriage is insufficient. The recommendations in this chapter serve as evidence-based practices for nurses and other healthcare professionals working with this population. Each reference used to justify a recommendation for practice includes the article's "Level of Evidence"; the definitions of which can be found in Appendix B.

Assessment of Emotional Needs

As soon as the diagnosis of miscarriage has been confirmed, the nurse working with the patient should assess the woman's emotional needs. Providers reported in Gergett and Gillen's (2014; level VI evidence) study that they initially focused on the woman's physical needs rather than her emotional state. Although miscarriage is a physical ailment and the physical symptoms of the condition do need to be addressed, women have expressed the importance of having an emotional connection with their nurses; they report wanting to feel empathy, sympathy, and reassurance from their providers (Radford & Hughes, 2015; level V evidence).

Before assessing the patient's needs, it is important that the nurse examines his or her own feelings towards miscarriage. The study by Engel and Rempel (2016; level VI evidence) revealed that healthcare provider opinions are divided on whether miscarriage is a normal event so that a woman should simply be able to "move on." Although miscarriages are not uncommon, to the woman experiencing the event it may be a traumatic loss, and it should be treated as such unless the assessment of the woman's emotions reveals otherwise. According to Gergett and Gillen (2014; level VI evidence), healthcare providers report that they are more likely to sympathize with a woman experiencing a stillbirth or a neonatal death than with a woman experiencing miscarriage. Thus, it is recommended that providers become aware of their own

opinions and biases and ensure they treat every woman experiencing the loss of a child equally, regardless of the gestational age of the fetus.

Not all women will react to a miscarriage in the same way, which is why assessment is key. Women who did not intend to get pregnant in the first place may not have the same emotional reaction to the news as women who have been struggling to get pregnant. Based on the study by Huffman, Schwartz and Swanson (2015; level IV evidence), it is recommended that the nurse assess the following parameters: age of the mother, the mother's mental health, past experience with infertility, number of living children, number of prior miscarriages, and gestational age of the child at the time of miscarriage. All of these factors can affect how a woman may react to the news of the miscarriage. Although it is important to assess these issues in the father as well, this Thesis has focused on the needs of the mother. The study by Huffman et al. (2015) found that grief experienced in earlier miscarriages tended to be less than in those that occurred at a later gestational age. It also found that couples who have a history of miscarriage and infertility are more likely to experience grief. Trends in the data like this can be useful to the nurse so he or she knows what to anticipate, but nothing is more important than asking the woman how she feels about the miscarriage. By taking a history of the mother's feelings toward her pregnancy and what this loss means to her, the nurse will be more likely to empathize with her, which will help strengthen the nurse-patient bond and help the patient feel validated in the loss.

A reoccurring theme in the literature deals with the use of medical terminology. Providers are not sure if the use of medical terminology helps reduce emotional stress on the family, and women often report that using medical jargon can be confusing and seem insensitive (Gergett & Gillen, 2014; Robinson, 2014). It is recommended that the nurse assess how the woman feels

about the use of medical terminology before her diagnosis and treatment options are explained; this allows the woman a measure of control and makes her an active participant in her learning.

Recognition of the Loss

Regardless of the nurse's personal beliefs, it is important to recognize that a miscarriage can be a significant loss to the mother. One of the major reasons women have reported feeling dissatisfied with their care is that they feel that their healthcare providers did not recognize their loss (Geller, Psaros, & Kornfield, 2010). By exploring what the miscarriage means to the woman, the nurse validates the mother's feelings of loss. Not only did the woman lose a child, but some women report a sense of personal failure in addition to losing her identity as a mother (Radford & Hughes, 2015). It is recommended that nurses offer condolences and assess what needs the mother might have to honor her lost pregnancy, such as conducting religious ceremonies, securing mementos, or naming the child. The systematic review conducted by Robinson (2014; level VI evidence) found that ceremonies and rituals can be very helpful to mothers who are coming to terms with their loss.

Ensuring Confidence

It is crucial that the patient feel confident that a miscarriage is truly occurring and that her chosen method of terminating the pregnancy is the best fit for her.

Confidence in Diagnosis

The study conducted by Limbo, Glasser, and Sundaram (2014; level VI evidence) concluded that a woman experiencing miscarriage must have confidence in the diagnosis before she is willing to think about possible treatment options. The study revealed that the level of evidence needed by women can vary widely; some women feel instinctively that something is not right, while others require multiple ultrasounds before they can feel confident in the

diagnosis. It is recommended that the nurse assess the mother and determine what level of information she needs to feel confident that what she is experiencing is, in fact, a miscarriage. Because many women reported fear of ending a viable pregnancy, it is vital to establish confidence that the pregnancy is not viable before presenting the patient with treatment options.

Confidence in Treatment Choice

Multiple factors go into deciding what treatment choice is right for the woman experiencing miscarriage, and it is important that the nurse explains the different options carefully and assesses how the woman feels about the different options given to her. The study by Schreiber et al. (2016; level VI evidence) found that it is essential for women to feel in control of how their pregnancy is terminated, so it is recommended that thorough information is given about the options so the woman can feel like she is making an informed choice. The study conducted by Olesen, Graungaard, and Husted (2015; level VI evidence) discovered that providers incorrectly assumed that women would choose their treatment options by weighing the biomedical pros and cons. In reality, there was a major emotional component in deciding which option to choose. Some women could not handle having the abortion at home, so they elected surgical treatment. Some women were afraid of anesthesia, so they elected medical or expectant treatment. Women reported frustrations when their feelings were not addressed prior to the implementation of treatment. It is recommended that the nurse assesses the potential emotional impact of each treatment method with the patient before implementing a treatment plan.

Proper Education

Education of the Healthcare Providers

The study conducted by Engel and Rempel (2016; level VI evidence) found that nurses were the least likely of all healthcare providers in feeling prepared to offer support to women

experiencing miscarriage. In the study conducted by Gergett and Gillen (2014; level VI evidence), providers identified lack of training as a reason it was difficult for them to encourage patients to discuss their feelings. These two studies demonstrate that improved healthcare provider education is needed, both as to the emotional impact of miscarriage and the techniques to address these emotions. Because much of the medical literature reveals a lack of understanding by providers of the full range of patient needs in this area, the other recommendations included in this chapter should become available to all providers, nurses in particular, who may come in contact with a woman experiencing a miscarriage. Additional education in school, as well as on the job, may be necessary to ensure proper care is given to this population.

Education of the Patient

Once providers are properly educated on miscarriage and its emotional consequences, they must be able to accurately relay the necessary information to their patients. According to Robinson (2014), women reported suffering anxiety over the severity of their symptoms, complaining that their providers did not accurately paint a picture of what the experience would be like. In the study by McLean and Flynn (2013; level VI evidence), patients reported wanting more information about what was happening to them and what to expect in the future. Similarly, Geller, Psaros, and Kornfield (2010) reported that women felt they were not given enough information regarding what was happening to them. All three of these studies show that there is a disconnect between provider teaching and patient understanding about the experience of miscarriage. This disconnect causes anxiety and increases that patients' dissatisfaction with their care. Although it is important to validate the patient's feelings about the miscarriage, sugar-coating the situation does not adequately prepare her for what she will experience. It is

recommended that providers be sensitive, yet honest, about the sights, sounds, smells, and physical discomforts that are involved with miscarriage. This is especially important with patients opting for the medical or expectant treatment, where the miscarriage will occur outside of the hospital. Providers should assess the ways in which a patient learns best and try to tailor their teaching to that style as much as possible. Women should be given ample time to ask questions while in the hospital, and providers should ask their patients to describe their understanding to ensure that information was communicated correctly.

Follow-Up Care

The study by Robinson (2014) found that 95% of women felt that post-miscarriage support was needed and that existing interventions were not enough. Although follow-up care does not necessarily take place in the hospital and therefore is not the main focus of this Thesis, hospital nurses are capable of discussing follow-up care with their patients before they leave the hospital. According to the study conducted by Nikcevis and Nicholaides (2014; level II evidence), women who received psychological counseling post-miscarriage reported a better understanding of their loss than those who did not receive the counseling. Another study by Johnson and Langford (2015; level II evidence) found that women who received bereavement interventions were more likely to report lower levels of grief than those who did not receive the interventions. Based on these two studies, it is recommended that the nurse discuss with her patient possible follow-up interventions to help address grief over the miscarriage. The nurse should also assist the patient in accessing her options, such as setting up appointments with a counselor or giving the woman a list of follow-up care providers that she can contact on her own.

Conclusion

Research studies highlight the need for best practice recommendations in five major areas. First, nurses should assess their patients' emotional needs as well as physical symptoms, guard against bringing their own biases or preconceptions into play, carefully consider the patients' particular circumstances, and encourage them to discuss their feelings. Second, nurses should look for the best way to recognize the pregnancy loss and validate the patients' feelings by offering condolences and inquiring whether any ceremonies or rituals might be desired. Third, nurses should strive to bolster patients' confidence that the miscarriage diagnosis was correct and that their choice of treatment was appropriate in light of both biomedical and emotional factors. Fourth, nurses should receive training regarding the emotional impact of miscarriage and techniques to address psychological distress so that they are better able to explain the process of miscarriage and respond to their patients' questions and concerns. Fifth, nurses should recognize the importance of follow-up care, discussing the possibility of grief counseling or other mental health services and offering patients a list of suitable providers.

Chapter Four: Plan for Implementation and Evaluation

This chapter will focus on the hypothetical implementation and evaluation of a hospital protocol established with the best practice recommendations outlined in Chapter Three. The protocol, located in Appendix C, will be accessible electronically from the hospital's charting system so that it is available to anyone who may encounter a patient having a miscarriage. Although it is most likely that this protocol will be utilized in the Emergency Department setting, miscarriages can happen anywhere at the hospital, so it should be made available to everyone. The protocol will automatically open in the electronic health record when the diagnosis of miscarriage or potential miscarriage is entered into the system for easy access. This will serve as a reminder of evidence-based practices most likely to result in quality patient care. Although it would be preferred to have educational courses for providers on how to properly work with this population, establishing a protocol is an important first step in improving care for these patients. As discovered by Engel and Rempel (2016), approximately 64% of providers reported that they did not have any policies regarding miscarriage or were not sure if policies even existed.

Many different models exist to guide the implementation of research findings into clinical practice. For purposes of this paper, the Iowa Model of Evidence-Based Practice to Promote Quality Care (Iowa Model.) This model was selected because nurses tend to find it intuitive and logical, and it is often used in academic settings and healthcare institutions (Brown, 2014). The Iowa Model includes the following steps: identifying triggers, determining if the topic is a priority, forming a team, assembling relevant research and related literature, analyzing the research for practical use, determining if there is sufficient evidence, piloting the change into practice, determining if the change is appropriate, instituting the change into practice, monitoring and analyzing data, and finally, disseminating results (Brown, 2014).

Implementation

Triggers

According to the Iowa Model, there are two different types of “triggers” that show that an evidence-based change may be warranted: a problem-focused trigger or a knowledge-focused trigger (Brown, 2014). A problem-focused trigger describes evidence-based change prompted by hospital data, financial data, or identification of a clinical issue (Brown, 2014). A knowledge-focused trigger involves evidence-based change brought about by new research findings or the need for new practice guidelines (Brown, 2014). The knowledge-focused trigger is a more appropriate fit in this instance because of the research included in this paper and the lack of policies, practices, and protocols regarding miscarriage.

Priority for the Organization

Once it has been established that there is a need to change practice, it must be determined whether the organization, department, or unit of a hospital sees value in implementing a change (Brown, 2014). Changing practice costs time and money, so in order for organizations to be motivated to create change, there must be adequate incentive to do so. If the change is related to the Mission Statement or Vision of the hospital, it may be seen as a priority, and the process can continue. If the potential benefit of the change is outweighed by the cost, the change may be seen as a priority, and the process can continue. If for some reason the trigger is not seen as a priority to the hospital, the Iowa Model suggests considering other triggers that may make the change more of a priority (Brown, 2014).

Persuading organizations to view miscarriage support as a priority may be a challenge. History and current research show that miscarriage has not been considered a priority in the past, as evidenced by the lack of policies in place (Engel & Rempel, 2016). An appeal can be made to

the hospital, organization, or department about the benefits of adequate patient care in this area. Miscarriage is a common-enough occurrence that if a hospital does not provide adequate care to these patients, it may deter future patients from using their services. If a woman comes in for a miscarriage and she is treated poorly or feels that her needs are not being met, she or her loved ones are unlikely to return to the facility for future medical needs. In addition, most hospitals have Mission or Vision statements that include providing the highest quality care possible. The implementation of evidence-based change regarding miscarriage could help the hospital further achieve that goal.

Forming a Team

Once it has been established that the needed change is a priority for the hospital, a team must be formed to discuss ways to develop, evaluate, and implement the change (Brown, 2014). Teams should be interdisciplinary and include everyone who could potentially be affected by the change (Brown, 2014). The composition of the team would vary based on the change that is being addressed (Brown, 2014). Potential teams that could be formed to address changes in miscarriage support may include staff nurses, charge nurses, managers, physicians, nurse practitioners, midwives, pharmacists, and case managers.

Assemble Relevant Research and Related Literature

After a team is formed, the next step is to gather research and literature related to the proposed change (Brown, 2014). This includes the formation of a good question to guide research (the PICOT method is suggested) and then conducting a review of the literature related to the topic (Brown, 2014). This is the same method that was utilized for this paper when conducting the literature review in the Chapter Two: a PICOT question was formed, and the discovered research was analyzed for its appropriateness to the topic in question. If a team

wished to find research on the topic of miscarriage, they could use the PICOT question that is outlined in this paper in Chapter Two.

Critique and Synthesize Research for Use in Practice

Once the research has been collected, the next step is to determine if the research is valid, reliable, applicable, and scientifically sound (Brown, 2014). All research comes with its own strengths and weaknesses, and it is up to those analyzing it to determine if the strengths and findings outweigh the potential weaknesses in design and setbacks in testing. For example, having a small sample size can limit the generalizability of the findings of the study, so its results may not be as applicable as a study with a large sample size. The level of evidence can also play a role in the strength of the findings. Explanations for the different levels of evidence are located in Appendix B. Generally, the higher the level of evidence, the more scientifically sound the research is. Advanced practice nurses and nurses experienced in critiquing research are vital members to have on a team (Brown, 2014).

The theoretical protocol that this paper suggests implementing is based on research with varying levels of evidence, varying sample sizes, and varying countries of origin. Even so, they all share similar conclusions, which strengthen the recommendations included in the protocol. The literature review in the second chapter of this paper includes analysis of the strengths and weaknesses of each article included in the formation of the protocol, and each article was analyzed for its applicability to the field of nursing. This review could be made available to a team, and if they determine that the evidence included is sufficient, they would not need to conduct their own research on the matter.

Determining if There is a Sufficient Research Base

After critiquing and analyzing the evidence, the team needs to decide if the research is sufficient enough to implement a change in practice (Brown, 2014). There are four main criteria that are used to determine if research is sufficient: 1) findings from numerous studies are consistent and support the change; 2) the quality and type of the studies; 3) the clinical significance of the findings; 4) the number of studies with similar sample demographics; 5) the feasibility of implementing the findings into practice; and 6) the risk-benefit ratio (Brown, 2014). If most of these criteria are met, it can be determined that the research is sufficient to justify the change in practice, or in this case, the implementation of a new hospital protocol.

Pilot the Change in Practice

Once it has been determined that the research supports a change in practice, the change must be tested on a small scale to make sure that it is practical and will result in the desired positive outcomes set by the team. If the team determines that the pilot change has been successful, the change can be implemented to larger areas of the hospital. The pilot process typically includes the following steps: 1) determine the outcome to be achieved; 2) collect baseline data; 3) design evidence-based practice guidelines; 4) implement guidelines on pilot units; 5) evaluate the process and outcomes; and 6) modify the practice guidelines (Brown, 2014).

A good place to pilot the miscarriage protocol would be in the Emergency Department (ED). This is the unit that will most likely encounter patients of this population, which will best allow the protocol to be evaluated for effectiveness. Staff on the unit will be made aware of the upcoming changes via email, as well as announcements during shift huddles and unit staff meetings.

A desired outcome for the protocol implementation is to improve patient satisfaction with the care received around the time of diagnosis and treatment of miscarriage. Surveys can be done in the ED prior to the implementation of the protocol to establish a baseline. This survey should include questions answered by a “strongly disagree to strongly agree” scale, along with a short-answer section which allows the patient to detail things that she appreciated and things she wishes would have been different with regard to her care. This baseline data can be integrated into the theoretical protocol based on research evidence. After the protocol has been implemented, new surveys should be conducted and evaluated to see if the protocol did improve patient attitudes towards the care received. If the data supports an improvement in the quality of care, and if the implementation process went smoothly enough, the protocol can be spread to other areas of the hospital.

Evaluation

Monitor and Analyze Structure, Process, and Outcome Data

Evaluation occurs during the pilot phase of the Iowa Model, but it also occurs continuously after the practice has been fully implemented. The model lists four components that need to be monitored and analyzed to assure that the practice continues to be cost effective and evidence-based: environment, staff, cost, and patient and family satisfaction (Brown, 2014).

There are three main types of evaluation: structure, process, and outcome evaluations. Structure refers to the physical setting and tools that a facility has, including equipment, administration structure, systems, staff, and operations (Donabedian, 2005). Structure variables are usually concrete and data is easily accessible, which makes it relatively easy to assess (Donabedian, 2005). In implementing the protocol, the structural evaluation would focus on the

charting system and the protocol itself, including whether the protocol is easily accessible and opens as it should when the diagnosis of a possible inevitable miscarriage is made in the system.

Process evaluations examine how care is provided in terms of appropriateness, acceptability, completeness, or competency (Donabedian, 2005). The nurses' ability to implement the protocol would need to be fully evaluated. What barriers are there to delivering the care recommended? Is there not enough time to implement the protocol? Is it being implemented at all? This information would be gathered through a survey of the staff at the end of the trial period.

Finally, outcome evaluations focus on end points of care, including improvement in function, recovery or survival (Donabedian, 2005). For the purpose of this protocol implementation, the outcome that is being evaluated is the patient's satisfaction with her care. This can be assessed with a survey that will be sent home with the patient at the completion of care. This method of evaluation is limited, however, because not everyone will complete the survey, and those who feel motivated to complete the survey may have a particularly polarized experience.

If evaluations of the protocol continue to show positive results as it is implemented throughout the hospital, then the protocol can remain the same. However, if new problems arise, or new knowledge is gained that could trigger additional change, the cycle begins again until a new practice is implemented.

Disseminate Results

The final step of the Iowa Model is to share and disseminate results (Brown, 2014). There is no reason for a successful protocol change to be limited to just one hospital. The research included in this paper indicates a widespread need for this type of protocol, so it is vital that the

successful implementation of the protocol be shared. This can be done via hospital networks, scholarly journals, and conferences.

Strengths, Limitations, and Recommendations for Future Research

The strength of this thesis lies in the detailed literature review, the careful critical analysis of the research, and the variety in the literature included. Although each individual article has its own flaws, the most prominent weakness being small sample size, the collective total of the findings validate the generalizability of the studies. The evidence-based recommendations and the theoretical protocol created in this paper are based on a variety of levels of evidence, sample sizes, and countries of origin. The validity of the protocol is strengthened by these varying types of evidence; even though the studies differ in their methods and demographics, they all reach the same conclusions.

The main limitation of this thesis is the relative lack of evidence in this area. Although miscarriage is a fairly common occurrence, current research on the topic is inadequate. The author suggests additional research in two main categories: interventions that assist in recognizing and validating the loss for the mother, and the special impact that infertility issues or multiple miscarriages might have for the patient. The first category is a priority, considering that most of the studies emphasize the importance of acknowledging the woman's loss, but very few articles detail specific ways to recognize that loss. Although the author was able to find an article stating that rituals and ceremonies can be helpful, no details were provided. This category of research should include culturally-sensitive interventions for woman experiencing miscarriage.

The second research category is outside the scope of this thesis, but is briefly mentioned in some of the articles included: the impact of miscarriage after infertility and/or multiple pregnancy losses. Both were listed as factors that contribute to a woman's reaction and feelings

towards her current miscarriage. Although this thesis suggests that nurses and other providers assess these circumstances, the author could not find any articles that explain how these specific problems impact the woman's grief and how the caregivers can best respond.

Summary

The main purpose of this thesis was to identify deficiencies of care in the treatment of women experiencing miscarriage and to establish evidence-based recommendations to promote quality patient care and improve patient satisfaction. Research shows that the care that is currently being provided to women is insensitive and inadequate. The results of the literature review show that providers lack the education, the sympathy, and the organizational support that is needed to work with this population. This thesis provides detailed explanations of recommendations, with relevant research evidence, which should be implemented into the everyday practice of nurses and other providers who work with this population. In order to facilitate the implementation, a theoretical protocol has been designed, and the Iowa Model was used to outline a potential plan for implementation and evaluation that could be used by hospitals and other organizations. Although miscarriage is a relatively common occurrence, there are still areas of research that need to be further fleshed out. As more research is conducted, the recommendations and protocols detailed in this thesis should be revised.

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Appendix A: Table of Findings

Author(s) and Date	Questions, Variables, Objectives, Hypothesis	Design, Sample, Setting	Findings	Notes
Engel, J. & Rempel, L. (2016)	The purpose was to understand the relationship between attitudes of healthcare providers about miscarriage and how those attitudes affect care for the women and their families.	An electronically distributed survey design, that surveyed 174 healthcare providers, including 63 RNs, recruited from Ontario healthcare settings in Canada.	Opinion was divided on whether women should “just move on” with their lives. Responses were divided on whether miscarriage is a normal event. 43% of participants reported there were no policies regarding miscarriages in their areas of practice. RNs were the least likely of the healthcare professionals to mobilize support and provide information to the mothers, and they were significantly less likely to feel prepared to provide support. The more experience a healthcare provider had, the less support and information they provided.	Quantitative study. Lack of empathy is a big issue in women’s experience with healthcare providers. Sample included a wide variety of healthcare providers. Providers who believed anxiety and depression to be normal were less likely to provide support.

Radford, E. J., & Hughes, M. (2015)	The purpose was to investigate women's experiences of miscarriage in the first 16 weeks of pregnancy by exploring themes in literature since 1990.	Four databases were used, 47 abstracts were found, 22 were relevant and only 9 met the criteria for inclusion/exclusion. These 9 papers represent the experiences of 211 individual women.	Five of the studies identified that women wanted more emotional interaction with the nurses. Women felt a sense of personal failure with the loss of motherhood. Women wanted to have information about their condition and the interventions they were undergoing. Seeing pregnant friends caused pain, distress, and envy.	Mentions the weaknesses in the articles that are reviewed. Not a lot of quotes were used to support the themes. The review presented a more globalized take on care, for the studies came from several different countries.
Nikcevis, A. V., & Nicholaides, K. H. (2014)	The purpose was to analyze how "finding meaning" helped women cope with their miscarriage.	127 women, mostly white, older, and upper class, recruited from three different hospitals in London participated in this longitudinal randomized-controlled study.	Women who found understanding of their loss by four weeks post-miscarriage were less likely to think about the cause of their loss. The group which received further psychological counseling was more likely to reach an understanding of the cause of their loss than the control group.	The authors cited previous articles that they wrote themselves. Notes drop-out rate. Establishes statistical significance. The findings could be explained by simply time passing since the loss.
Olesen, M. L., Graungaard, A. H., & Husted, G. R. (2015)	The purpose was to learn how women make treatment decisions.	11 qualitative, semi-structured interviews were given in Denmark in this grounded theory study.	Women's choices were often based on unspoken emotional considerations.	Detailed procedure about how the themes were found.

			<p>Women who chose medical treatment did so partly because of fear of anesthesia.</p> <p>Women who chose surgical treatment claimed they could not cope with having an abortion at home.</p> <p>Women appreciated the ability to decide their form of treatment.</p> <p>Women receiving medical treatment would often call nurses asking for clarification of information that had been forgotten or misunderstood.</p>	<p>There is not a lot of information about the demographics of the sample. Most of the mothers were older.</p>
<p>Johnson, O. P., & Langford, R. W. (2015)</p>	<p>The purpose was to determine if women who were given immediate bereavement intervention in the hospital experienced less grief at the 2-week follow up than those who did not.</p>	<p>Randomized control study of 40 women in an obstetric emergency center in south central US.</p>	<p>The women who received the bereavement protocol reported lesser levels of overall grief. The experimental group experienced 50% less despair than the control group.</p>	<p>The study only included a posttest at the 2-week mark. No pretest was done, so there was no baseline for comparison. Early miscarriage needs to be recognized as a significant event. Validating that a pregnancy existed and that a loss occurred may help in the grieving process.</p>

<p>Robinson, J. (2014)</p>	<p>The purpose was to determine the importance of information and support to women who have experienced an early miscarriage.</p>	<p>Systematic review of four qualitative and one quantitative study found using CINAHL, Medline, PsychInfo, Amed and Ovid.</p>	<p>False reassurance is an issue: women were told that bleeding was normal, and then they experienced a miscarriage. Women experienced increased anxiety when their symptoms were worse than they expected them to be. Use of medical terminology and insensitive comments added to women's lack of understanding and frustrations. Ceremonies/rituals have had a positive impact in coming to terms with the loss. Women do not seem to actively seek support, even though they see support as important.</p>	<p>There were not a lot of studies included in the review, which could limit its analysis. Weaknesses in the articles included were mentioned.</p>
<p>Limbo, R., Glasser, J. K., & Sundaram, M. (2014)</p>	<p>The purpose was to understand women's decision making process after learning that miscarriage is inevitable.</p>	<p>This was a two-phase qualitative design with dimensional analysis of 23 women in a midsized Midwestern medical center.</p>	<p>The theme that stood out was "being sure," mostly in two contexts: the need to be sure of the diagnosis and the need to be sure of the treatment option. Women needed to feel certain that</p>	<p>Limitations of the study were not noted. Experiences are individualized and treatment needs to be as well. The study gives examples of questions that nurses can ask</p>

			what they were experiencing was in fact a miscarriage; some felt sure after an ultrasound, but one participant did not even feel sure after having three.	to help assess how sure a woman is about her diagnosis and treatment.
Schreiber, C., Chavez, V., Whittaker, P. G., Ratcliffe, S. J., Easley, E., & Barg, F. K. (2016)	The purpose was to describe the factors that are prioritized by patients and doctors during management of first-trimester miscarriage and to assess what makes patients satisfied with their care.	This was a mixed-methods study that involved demographic and psychosocial surveys of 55 women and in-depth interviews with 45 women who were seeking surgical, medical, or expectant miscarriage management. Purposive sampling was used to determine the participants. Physicians were also interviewed, and data saturation was reached after 15 interviews.	The study found that the main factors that influenced a woman's choice of medical management were her socioeconomic status, the opinions of the people she trusts, her experience with her current pregnancy, her past experiences (or lack thereof), and the length of time required for treatment.	All of the participants were from one clinical research site, and all were English-speakers, so may not be very generalizable. Data saturation was used with both samples. The interviews with the physicians matched up with the interviews with the women. Both reported the same priorities when deciding on treatment.
Huffman, C. S., Schwartz, T. A., & Swanson, K. M. (2015)	The purpose was to explore the effects of gender, age, mental health history, and reproductive factors on couples'	This study is a cross-sectional comparative study with RIMS data gathered from the Couples Miscarriage Healing Project (CMHP), which is a randomized	The study found that men reported that the miscarriage had significantly less impact on them than on their female partners. Age has a greater effect on feelings	The study provided a new take by analyzing the impact of miscarriage on the couple, as well as on the individual.

	<p>responses to miscarriage.</p>	<p>controlled clinical trial assessing the effects of three theory-based interventions on 341 couples' grief and depression in the first year after miscarriage.</p>	<p>of isolation and grief than history of mental health treatment. Couples with a history of infertility had higher levels of devastation, isolation and grief than the couples without such history. Those with a history of miscarriage were also significantly more devastated than those with no history of miscarriage.</p>	<p>Even though the study had a large sample size, the sample was mostly white, college-educated, and middle-class.</p>
<p>Gergett, B. & Gillen, P. (2014)</p>	<p>The purpose of this study was to explore perceptions of healthcare professionals caring for families who have experienced miscarriage.</p>	<p>This is a qualitative study with purposive sampling. All participants came from one health and social care trust in Northern Ireland. Data was collected with 39 professionals participating in focus groups and 10 professionals participating in one-on-one interviews.</p>	<p>Healthcare professionals admit that they are more likely to feel sympathy for a stillbirth or a neonatal death than a miscarriage. Providers mentioned that a lack of training made it difficult for them to encourage women to talk about how they are feeling after they find out about the miscarriage. Providers admitted that in the initial stages, the physical needs of the women took priority over their emotional needs.</p>	<p>The study recognized the difficulty faced by providers in helping patients who did not speak English.</p>

			Providers are often not sure whether it is better to use medical terminology or not, in order to reduce the emotional stress on the family.	
McLean, A. & Flynn, C. (2013)	The purpose of this study was to discover the experience of women attending a hospital for a miscarriage in the first 20 weeks of pregnancy.	The authors of this study referred to it as exploratory research. It gathered qualitative data on the views and experiences of 6 women who experience miscarriage. Interviews were recorded and transcribed, and themes were drawn from the transcriptions.	Women felt that treatment needed to be more consistent and specialized. They wanted to feel more compassion and understanding from their providers. They wanted more information on what was happening to them and what to expect in the future. There was a clear lack of communication between the participants and their providers.	The authors recognize that the sample size and location was limited.
Geller, P. A., Psaros, C., & Kornfield, S. L. (2010)	The purpose was to explore whether women who received the “typical” health services after early pregnancy loss were satisfied with their care.	This study is a systematic review of 16 studies on women and their experiences with early pregnancy loss. PubMed, PsycINFO, and CINAHL were used to collect the articles.	Women who were dissatisfied reported that their providers did not recognize their loss, that they were not given adequate information, and that they were treated in a “business-as-usual” type of manner.	This review recognizes all of the individual flaws and strengths of the articles that are included.

Appendix B: Levels of Evidence

Level of evidence (LOE)	Description
Level I	Evidence from systematic review or meta-analysis of randomized control trials or evidence-based clinical practical guidelines based on systematic reviews.
Level II	Evidence from at least one well-designed randomized control trial.
Level III	Evidence from well-designed controlled trials without randomization; quasi-experimental.
Level IV	Evidence from systematic reviews of descriptive and qualitative studies.
Level VI	Evidence from a single descriptive or qualitative study.
Level VII	Evidence from the opinion of experts,

Information retrieved from: Ackley, B. J., Swan, B. A., Ladwig, G., & Tucker, S. (2008). *Evidence-based nursing care guidelines: Medical-surgical interventions*. (p. 7). St. Louis, MO: Mosby Elsevier.

Appendix C

Theoretical Protocol

Clinical Practice Approval Form

Clinical Practice Title: Recommended Treatment for Early Pregnancy Loss	
Type of Review: <input checked="" type="checkbox"/> New Clinical Practice <input type="checkbox"/> Revisions of Existing Clinical Practice Original Approval date:	Care Management Council submission date:
Clinical Practice Owner / Author: (e.g., CCG and WG Lead(s) named)	Contact Information
Daria L. Schaefer, BSN Honors Student	Name: Daria L. Schaefer
	Phone: (623) 666-2151
	email: dbadie@email.arizona.edu

Type of Clinical Practice:	<input type="checkbox"/> Expected	<input checked="" type="checkbox"/> Recommended	<input type="checkbox"/> Optional
Brief Description of Clinical Practice			
This clinical practice outlines evidence-based practice recommendations to healthcare providers on how to best care for women who are experiencing inevitable miscarriage. Recommendations include provider behaviors and actions, as well as interventions that may help the patient cope with the loss she is experiencing.			
Departments/Disciplines Affected			
Emergency Departments	Women's Health	OBGYN	

Reviewed History	
Reviewed by (name/group):	Date:
Clinical Practice Toolkit Link:	

Upon Care Management Council Approval, Clinical Practices enter DESIGN Phase in Care Management.

Care Management Council Approval	
<input type="checkbox"/> Returned to Author for Revision	Date:
Comments:	
<input type="checkbox"/> Approved by Care Management Council	Date:

TITLE: Recommended Treatment for Early Pregnancy Loss		
Number:	Date Posted: 11/25/18	
Type: Clinical Practice		Contact: Daria Schaefer, BSN Honors Student
Approved Date:	Implementation Date:	Deactivation Date:
Facilities:		
Approved by:		

Evidence-Based Treatment of Early Pregnancy Loss

PRACTICE APPROACH:

Expected/Recommended/Optional Clinical Practice

PRACTICE STATEMENT:

All women who are suspected to be experiencing miscarriage are to receive or be exposed to these practices. These practices should be implemented *prior* to the official diagnosis of miscarriage. If the woman or provider even suspects that the woman may be having a miscarriage, these protocols should be put into practice. Certain practices are not to be implemented until after the official diagnosis of miscarriage has been made. The purpose of these practices is to ensure that women experiencing

miscarriage are receiving adequate evidence-based care that is sensitive to their loss, as well as their preferences for care.

RATIONALE:

Despite how common miscarriage is, a large portion of providers report not having any established policies regarding miscarriage (Engel & Rempel, 2016). Of all healthcare providers, nurses felt that they were the least prepared to care for this population, and because of this, they were the least likely to mobilize support and provide information to the women (Engel & Rempel, 2016). Because nurses are the healthcare providers that spend the most time with patients, specifically in the Emergency Department, it is important that they are given the tools necessary to provide adequate care to this population (McLean & Flynn, 2013). This protocol serves as a guideline for nurses, as well as other healthcare providers, to show the basic standards of care for this population. In this manner, hospitals can ensure that they are providing the same level of care to all women experiencing miscarriage, and they can ensure that the care that is provided is sensitive and patient-centered.

Along with initial physical assessments which occur when the woman enters the healthcare setting, emotional needs should be assessed. Not all women react to miscarriage in the same way and there are many factors that go into the level of grief she may or may not feel (Huffman, Schwartz, and Swanson, 2015; Limbo, Glasser, & Sundaram, 2014). One of the major complaints found in the literature is that women feel that their providers only focus on their physical needs, and not their emotional needs (Radford & Hughes, 2015; Gergett & Gillen, 2014; McLean & Flynn, 2013). Women in these studies reported that they would have been more satisfied with their care if their emotional needs were recognized with the same degree as their physical needs.

Research shows that women must have confidence in the diagnosis of miscarriage before they are willing to discuss treatment options (Limbo et al., 2014). The type of information women need to feel confident varies, so the nurse and other healthcare providers must assess each woman about what she personally needs to be sure that her diagnosis is correct.

Providers sometimes have the misconception that women choose their treatment options based on the biomedical pros and cons of each treatment option; however, the reality is that many women are driven by undisclosed emotional considerations when they make the final decision (Olesen, Graungaard, and Husted, 2015). Nurses and other providers should assess these emotional considerations when discussing treatment options so that women are able to make truly informed decisions. Providers should not hold back when describing the physical symptoms that a woman will experience as she goes through the different treatment options. A study by Geller, Psaros, and Kornfield (2010) found that women felt they were not given enough information about the physical discomforts involved with miscarriage and treatment. Many women went back in for additional treatment, searched for answers on the internet, or called medical help lines for additional information, all of which should have been avoided with proper education in the first place (Geller et al., 2010). Avoiding the use of medical terminology is recommended, because it can come across as insensitive and can be confusing and upsetting for the patient (Gergett & Gillen, 2014; Robinson, 2014).

One of the major reasons that women report being dissatisfied with their care is that their healthcare providers do not recognize their loss (Geller et al., 2010). Culturally sensitive ceremonies and rituals can be beneficial, as well as securing mementos or naming the child (Robinson, 2014). Research shows that providers tend to be more sympathetic towards women

who suffer stillbirth or neonatal losses, but providers must realize that miscarriage is often experienced as a loss of a child, and should be treated as such (Gergett & Gillen, 2014).

Research shows that women who receive follow-up counseling after their miscarriage tend to have a better understanding of their loss and experience less grief (Nikcevis & Nicholaids, 2014; Johnson & Langford, 2015). Therefore, it is important to offer women options that they can pursue after they leave the hospital to help them grieve.

All of these changes can help increase a woman’s satisfaction with her care during miscarriage. For more information and evidence, please refer to the thesis “Unrecognized Loss: How to Best Support Women Experiencing Miscarriage.”

CLINICAL APPROACH:

Procedure	Key considerations
<p>If a woman or provider believes that a miscarriage may be occurring, or may occur in the near future, the nurse or provider must do an “emotional needs” assessment. Assess the woman’s attitudes towards a potential miscarriage, and what a miscarriage would mean to her and her family.</p>	<p>Never assume how a woman may feel about a miscarriage. Keep in mind that not every woman will be upset if she discovers she is having a miscarriage. There is a chance that a woman does not want to be pregnant, so the news of a miscarriage may come with a sense of relief. However, before you are aware of her feelings, assume that this is a loss that is potentially significant to her.</p>
<p>Assess what the woman needs to feel confident that her diagnosis of miscarriage is correct. Do not discuss potential treatment options until the woman feels certain that she is experiencing miscarriage.</p>	<p>Some women feel sure by intuition, some are sure because of the physical symptoms, some need evidence such as an ultrasound, etc. If the woman is not sure she is having a miscarriage, she will not want to discuss treatment options for ending the unviable pregnancy.</p>

<p>When discussing potential treatment options, be sure to properly educate the woman about the sights, smells, and sensations she will experience with each treatment option. Discuss the possible pros and cons of each treatment option from both a physical and an emotional perspective. By doing these things, the woman can feel sure that the treatment option she is choosing is most suited for her.</p>	<p>Miscarriage is a time where a woman feels like she has no control. Giving her detailed information about treatment options gives some sense of control in an emotionally trying time. Emotional considerations can have more weight in the final decision than healthcare providers may expect. Do not forget to assess the woman's feelings and concerns towards the different options. When discussing treatment options, try to avoid medical jargon, because it can be confusing and upsetting to the woman and her family.</p>
<p>Throughout the assessment process, the diagnosis, and the discussion of treatment options, it is vital that healthcare providers recognize the woman's loss, if she perceives the miscarriage as a loss. Mementos such as ultrasound pictures and footprints should be offered, depending on the gestational age of the fetus. Having the woman name the child is recommended. Offer culturally sensitive rituals or prayers that meet a woman's individual grieving needs.</p>	<p>Treat the miscarriage loss with the same kindness, sympathy, and recognition as would be offered to a mother who has experienced a stillbirth or other neonatal loss.</p>
<p>Provide resources to women regarding follow-up care. This should include not only the physical follow-up care that is required for certain treatment options, but also emotional follow-up care. Offer resources for coping and grieving services that the woman can utilize. Provide the same information that would be given for any other type of loss.</p>	<p>For many, miscarriage is just as devastating a loss as other losses are, and it should be approached in a similar fashion.</p>

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