Spring 3-16-2018

Caring for The Bereaved Mother

Ivonne Rocio Guzman
iguzman@cse.edu

Care of the Bereaved Mother

By

Ivonne Rocio Guzman

DNP Final Scholarly Project Committee

Dr. Mary Ellen Roberts, Chair

Dr. Maureen Byrnes

Sheila Carr, RN-BC, MA, PCNS

Submitted in partial fulfillment of the Requirements for the degree of

Doctor of Nursing Practice

Seton Hall University

2018

Care of the Bereaved Mother

By

Ivonne Guzman

DNP Final Scholarly Project Committee

Dr. Mary Ellen Roberts, Chair

Dr. Maureen Byrnes, DNP, RN, CNM

Sheila Carr, RN-BC, MA, PCNS

Approved by the DNP Final Scholarly Project Committee:

Mary Ellen Roberts Date: 3/16/18

Dr. Mary Ellen Roberts

Maureen Byrnes Date: 3/16/18

Dr. Maureen Byrnes

Sheila E Carr Date: 3/16/18

Sheila Carr

Submitted in partial fulfillment of the Requirements for the degree of

Doctor of Nursing Practice

Seton Hall University

2018

Dedication

This project is lovingly dedicated to my parents Luis Antonio Guzman and Esther Guzman, who recently passed away thirteen months apart. They were always so loving, supportive, and encouraged all of my educational goals and dreams. I made a promise to pursue my DNP and I am keeping that promise in their memory**. *I love and miss you mom and dad.***

Acknowledgements

It is with deep gratitude that I mention Sheila Carr, nurse manager of the NICU nursery at St. Joseph's University Hospital for serving as mentor during the inception and implementation of this project. Her support allowing me access to the NICU nursery, staff nurses and NICU bereavement protocols was instrumental in helping me move forward with the project.

I offer sincere appreciation to Dr. Mary Ellen Roberts for providing support, guidance and encouragement throughout the course of the DNP program and this scholarly project. Her patience, understanding and positive feedback gave me the strength needed for the completion of this endeavor.

I would like to thank Joanne Beck, nurse manager of the Mother-Baby unit who was always supportive and provided encouragement whenever I had moments of doubt and uncertainty. Her enthusiastic positive feedback was always reassuring during my educational journey.

Thanks to Stephanie Giddens, clinical educator and bereavement coordinator for her support and enthusiasm during this project. She was a valuable resource who willingly offered her experience and helpful feedback for this educational project.

My sincerest appreciation goes out to Professor Karen Ramsdan, the nursing program coordinator of Passaic County Community College (PCCC), for always being an inspirational guide and encouraging me to continue my education to achieve greater endeavors. From my BSN to present, she pushed me to move forward in pursuit of higher learning and broadening my horizons.

I would like to thank Dr. Maureen Byrnes for all her early feedback and guidance during the process of this DNP project. Her support and enthusiasm provided the encouragement needed to move forward with this quality improvement project.

I also wish to express my deep appreciation to Dr. Diane McClure, for providing support during this journey back to school to pursue my DNP.

I wish to acknowledge all the strong women in my life, my girlfriends and coworkers most of whom are nurses for their invaluable support and encouragement during this at times difficult but rewarding educational journey.

Table of Contents

Personal Perspective: Project Impetus

Whenever people think of the Mother Baby Unit (MBU), they may imagine it to be the happiest place in a hospital. The joy and happiness that this event brings to the family is heartwarming. However, sometimes the unexpected happens, and as a healthcare professional, one may find herself in a situation which she is unprepared for, both emotionally and clinically.

One afternoon, a young Mexican mother was being admitted to the MBU. This was her second full term pregnancy, and she was being admitted for a scheduled routine repeat caesarean section. The patient was full term and had an uneventful pregnancy. During the course of her admission, it was determined no fetal heart rate (FHR) was detectable, and she had unknowingly suffered a full term fetal demise. Since the patient was Hispanic and non-English speaking, as a certified interpreter, I interpreted the findings for the physician. Once the information was given to the patient, everyone walked out of the room and left the young mother alone. Given she had just received devastating news, I found it difficult to understand how we could provide such little support or comfort for this grieving woman as she waited to be transferred off the MBU unit. The staff was uncomfortable dealing with a situation that was unfamiliar to them, so they avoided the patient. She was left to deal with this life changing event on her own with no comfort, support or follow-up.

On a second occasion, a young African American couple with their first pregnancy through in-vitro fertilization was admitted to the MBU for a scheduled caesarean section. The patient was getting prenatal care from a private high risk perinatologist who had monitored her pregnancy closely. She was full-term with no complications. As with the previous case, when the patient was placed on the external fetal monitor, there was no FHR. The physician was immediately called to assess the patient. The couple was devastated when they were informed

that they had suffered the unexpected loss of their full-term baby. Social work was notified, and they were offered spiritual assistance. She was transferred off the MBU to the antepartum unit so she would not have to hear babies crying on the unit as she struggled with her grief.

When these unexpected events occurred on the MBU, the staff was ill prepared to deal with the needs of these vulnerable patients. Since these were the first patients to suffer unplanned full term fetal demises, the staff was unsure of what appropriate interventions to use with the patients; therefore, the consensus was to give them "space" to deal with the tragedy of their situation, and to avoid them. The nurse's actions during these events demonstrated a gap in education and insight when caring for the bereaved mother.

The failure in the nurses' actions during these events presented an opportunity to learn and grow for all MBU nurses. Continuing education has always been a cornerstone in the nursing profession, and these actions identified the need to fill a gap in education in regard to appropriate patient care. To research the parents' bereavement experience and gain insight into what their care needs are during this difficult time, and to provide appropriate evidenced based comfort and support interventions provided the guiding structure for this project.

Abstract

Purpose: Caring for the bereaved mother can be a challenging undertaking for healthcare professionals who unless have suffered a similar loss, can find it difficult to relate with bereaved parents. The purpose of this DNP project is to research grief and bereavement to better understand the parental bereavement experience and to develop an education lesson for MBU nurses caring for bereaved patients. It is essential to provide nurses with insight into the bereavement experience of parents who have suffered the loss of a child, so they can provide support that validates the parents' grief and helps facilitate spiritual, emotional, or cultural rituals. Appropriate interventions can improve quality of care and promote healing.

Method**:** The project was implemented in collaboration with the NICU nursery, the NICU nursing staff, and the parents' bereavement support group coordinator. The goal was to research the bereavement experience of the parents, but more specifically the mother, through evidence-based research, interviews with NICU nurses of their interaction with bereaved parents, review of the existing bereavement protocol in the hospital, and observing a parents' bereavement support group to hear firsthand accounts of parents' experiences and perceptions of their nursing care by healthcare professionals. This gathered data was then structured into an education lesson for the nurses of the MBU.

Findings: The education lesson was positively reviewed by the stakeholders. Their feedback stated the information was relevant and brought awareness and insight for nurses caring for these vulnerable patients during a difficult time. The coordinator of the parents' bereavement support group suggested the lesson would be beneficial for newly hired nurses during orientation.

Clinical Relevance: Through education, nurses gain knowledge and an understanding of what their role is in the bereavement process of the mother who has suffered an unexpected perinatal loss. Learning to foster a caring and trusting relationship with patients creates a safe environment and forms a partnership with patients, which thus results in appropriate interventions that meet the specific needs of the mother. This also facilitates the development of an individualized plan of care that provides support, comfort and guidance through the bereavement process. Guiding parents through the bereavement process is an essential component of care that contributes to normal progression through the stages of grief and promotes wellbeing.

Background

"Each year more than four million infants are born in the United States. For most parents childbirth is a time of joy and happiness, but for some the birth can be devastating as they mourn the loss of their child" (Puia, Lewis and Beck, 2013, p.321). A fetal death, which is sometimes referred to as a stillbirth, takes place during pregnancy at 20 weeks gestation or more (American College of Obstetrician and Gynecologists [ACOG], 2009). In the United States 25,894 fetal deaths were reported in 2005.

A perinatal loss can be defined as the unplanned ending of a pregnancy at any time before or during birth. Despite advances in technology, perinatal loss statistics have remained relatively consistent. Over one million fetal deaths occur in the United States each year (Puia, Lewis and Beck, 2013). The occurrence of perinatal loss reflects a very real possibility that all nurses, even those outside of the maternal child division, will meet and care for a woman who has experienced a loss.

This death experience is especially devastating for the mother who has developed an emotional and physical bond with the fetus throughout the pregnancy, resulting in all the mother's dreams, hopes and anticipated future associated with the baby being lost. "Parental grief is felt as a deeply personal and unique response to the death of a child yet bereaved parents are joined by their experience, which is unparalleled and known only to them in ways that cannot be easily communicated to others" (Arnold & Gemma, 2008, p. 659).

Although physicians are present when the patient delivers, nurses spend the most time with the mother, from the delivery, throughout the post-partum period, as well as the postmortem care of the infant after the loss. Nurses face many challenges when caring for bereaved patients; they must address patients' physical problems and their emotional and mental needs, as well as

provide comfort and support throughout the grief process. Nurses with an understanding of the specific needs of the bereaved mother can help create a supportive environment providing comfort and building a caring and trusting relationship with the mothers as they navigate through the bereavement process together.

Definitions of Terms

Grief:

- A complex set of cognitive, emotional, and social difficulties that follow the death of a loved one
- Is subjective and expressed in many different ways by people
- It's a process that people go through in their own time and at their own pace.

Parental Grief:

- Grief experienced by parents who has suffered the loss of a child/infant

Grieving:

- Psychological components of bereavement, the feelings evoked and especially the suffering involved with a significant loss

Stages of Grief:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Mourning:

- Actions and manner of expressing one's grief
- It is important that a bereaved person adapt to her loss by working through the stages of grief.
- Once she has come to terms with the loss, she can start to handle the emotional impact of the loss.

Bereavement:

- A period of mourning after a loss, especially after the death of a loved one

(Bartellas & Van Aerde, 2003).

Description of Project

The project consisted of four components aimed at developing a nursing education lesson focused on caring for the bereaved mother/parent who has suffered an unexpected full term fetal demise. The four components included:

1. Conducting interviews with NICU staff to gather insight into their interactions with bereaved parents after the loss of an infant.
2. Attending a support group for parents to gain awareness into the parents' bereavement experiences, and their perception of the care they received in the hospital after having suffered an unexpected loss.
3. Developing an education lesson for MBU nurses on care of the bereaved mother through research of best evidenced based practices.
4. Implementing an education lesson to the nurses of the MBU, NICU and labor and delivery. Bringing this new knowledge as part of the education continuum to all the nurses of the Maternal-Child division.

Recipients of the Project Activity

The recipients of this project included two groups of people: the MBU nurses and bereaved mothers. The MBU nurses viewed the developed education lesson of evidence-based bereavement interventions gaining knowledge and thus being empowered to promote appropriate and individualized choices to achieve healthier outcomes and recovery. Secondly, the bereaved mothers who will benefit from the individualized care and support provided by the evidence based interventions and guidance as they navigate through the grief process were also involved in this project.

Purpose of Project

The purpose of this project is to develop and implement an educational lesson for MBU nurses and raise awareness of the grief experience of mothers who have unexpectedly experienced a perinatal loss in the hospital. Through staff interviews to gain insight into parental grief and bereavement, research of best evidence-based practices and review of existing bereavement protocols, an educational presentation could be effectively developed. Healthcare professionals must learn to understand how their words, actions and behaviors can have a profound impact on bereaved mothers. Furthermore, by guiding bereaved mothers through the normal grieving process on to recovery and well-being, positive outcomes can arise from these times of parental duress.

The project focused on empowering nurses through education and knowledge. Through education, nurses can learn to develop a caring and trusting relationship with bereaved mothers, allowing the nurse to individualize the plan of care to meet the specific needs of mothers as they go through the grieving process. The overarching goal of the project is to improve the quality of patient care leading to recovery, well-being and eventual resolution of grief.

Expected Project Outcome

The expected project outcome is the development of an educational lesson to address knowledge gaps in MBU nurses regarding the care of bereaved mothers who experience a perinatal loss. The bereaved mothers will benefit from the qualified and competent care from the MBU nurses after education and training received from the lesson plan.

Phases of Project Implementation

Phase I

This phase includes the identification of the need, problems and knowledge gaps that exist within the MBU. Identification of gaps in educational knowledge of the parental bereavement experience and care of the bereaved mother in MBU nurses was selected as the focus of this DNP project.

Phase II

The goal in this phase is to obtain support from the process stakeholders, which included the nurse managers of both the MBU and the NICU nursery, and the bereavement group coordinator. Since the project was consistent with the mission and goals of the organization, support was obtained with relative ease.

Phase III

This phase focuses on interviews with NICU nurses regarding their experiences with bereaved parents, as well as observation of NICU staff interactions with bereaved parents and existing bereavement protocols. The gathered data from the interviews, existing bereavement protocol, and researched evidence based interventions was constructed into an educational lesson presentation for the nurses on care of the bereaved mother.

Phase IV

This phase includes the ongoing implementation of the developed educational lesson for the nurses. The educational lesson was first previewed by the process stakeholders: nurse managers of the MBU and NICU nursery, the bereavement coordinator, and the NICU clinical coordinator. The lesson was initially presented to a small group of staff nurses from the MBU, NICU nursery, and labor and delivery.

Phase V

This phase involves the project evaluation process through discussions with identified stakeholders on the relevance of the educational lesson and the effectiveness of accomplishing its objective to provide knowledge of the bereaved mother for the nurses. The staff nurses who previewed the lesson were given an evaluation to complete post bereavement education on the relevance of the knowledge in their scope of practice. The nursing response of the educational lesson were positive; participants expressed taking away learned knowledge and a feeling of empowerment and being better prepared if faced with having to care for a mother who has suffered a perinatal loss.

Significance of the Project for Nursing

Nurses are often present during times of bereavement but may not necessarily have the knowledge, confidence, comfort or expertise to cope with the bereaved patient. Grief is a unique experience, and education on grief and bereavement can help healthcare professionals understand how parents deal with the loss of their child. By establishing perinatal bereavement standards of care, nurses can improve the probability of providing consistent and competent quality care. As nurses determine the bereaved mother's wishes and preferences and incorporate them into an individualized plan of care, the relationship between parent and nurse is confirmed, and appropriate honor for the deceased fetus and/or infant is provided.

Healthcare professionals should recognize their role at the time of a perinatal loss. With their support and understanding during the time surrounding the loss of the baby, nurses have the opportunity to play an important role in the healing of the bereaved mother. Nurses should learn how their actions and behaviors, such as small insensitivities, can take on importance and have a profound impact on bereaved mothers. Although difficult, nurses should work through their own

feelings and hopefully become comfortable discussing sensitive issues, such as death and bereavement. Likewise, they should be trained to help bereaved mothers navigate through the grief process. Although no one can take away the devastating effects of the loss, the nurse can potentially reduce negative effects and improve care of bereaved mothers as they recover.

Section II: Theoretical Framework and Literature Review

Theoretical Framework

The theories that provided the framework and guidance for this project included Bowlby's Theory of Attachment, which provides insight into the bereavement experience of parents who have suffered the loss of a child (*the bereaved mother*), Jean Watson's Theory of Human Caring and Swanson's Theory of Caring. These nursing theories complement each other and stress the importance of being emotionally present and knowing patients to get a better understanding of their needs. In such, nurses ae able to provide individualized care to meet those needs and promote well-being. The theories also emphasized creating a trusting and caring relationship with patients that demonstrates nurses' authenticity and interest in the bereaved patients.

Bowlby's Attachment Theory

Bowlby, a psychoanalyst, was the first bereavement theorist to base his conclusions on empirical evidence. His attachment theory discussed how the intensity of grief was influenced by the type of attachment that the bereaved had to the deceased person. He identified how the circumstances surrounding the death of a loved one affected the bereavement process. "His grief theory described a series of phases through which bereaved persons experience grief reactions and, in time, reach recovery" (Wright & Hogan, 2008, p.350). Understanding Bowlby's four phases of bereavement is essential in providing adequate care for bereaving mothers.

Phase One: Shock and Numbness

In this phase, there is a sense of loss and physical distress, which can result in somatic symptoms. The bereaved person experiences shock, numbness, denial with outbursts of anger and extremely intense distress, which is seen as a protective coping mechanism. If the person does not progress through this phase, she will shut down and struggle to understand and accept her emotions and fail to communicate them.

Phase Two: Yearning and Searching

This phase includes crying, anxiety, anger, and confusion. The bereaved person becomes aware of the void in her life from the loss. The future she imagined with her newborn is no longer a possibility. If the bereaved person fails to move through this phase, she will remain preoccupied with filling the void of the loss.

Phase Three: Despair and Disorganization

This phase is characterized by despair and disorganization as the bereaved person must learn to live life without her loved one. At this stage, the bereaved person has accepted the loss and understands things will be different from the way she imagined. There is hopelessness and despair, as well as anger and questioning. Failure to progress through this phase will leave the bereaved person consumed with anger, depression, negativity and hopelessness.

Phase Four: Reorganization and Recovery

This phase is characterized by reorganization and recovery; goals for the day-to-day life are established by the bereaved person. She slowly starts to rebuild and realize that life can still be positive, even after the loss. At this stage, grief does not go away nor is it fully resolved, but according Bowlby and Parkes (1970), starts to slowly recede to a hidden section of the brain,

where it continues to exist but is not at the forefront of her mind or day-to-day life (What's your grief.n.d.).

Bowlby's theory expresses the importance of the bereaved person navigating from each phase to the next to achieve a sense of well-being and recovery after her loss and failing to do so will prolong grief and lead to deeper depression causing further despair and isolation. Grief and bereavement are a normal process, and each person must go through them in her own time and at her own pace. It is important that appropriate support is provided throughout the process to assist with recovery, which places the healthcare professional in a unique position when caring for a bereaved person after a loss.

Jean Watson's Theory of Caring

Jean Watson's theory is focused on the human caring relationships between the nurse and patient that are viewed as the core of nursing practice. According to Watson (2006), a human-to-human caring relationship involves two persons who are affected by one another, share personal experiences and participate with one another. The theory discusses the significance of being authentic and present with and for the patient. This means being able to focus on only the other individual for this time. Focusing attention to what the patient is experiencing (grief over the loss of a child), to support her spiritual belief system and the things that will inspire hope or faith for the bereaved mother is imperative. The nurse must develop a supporting, caring and trusting authentic relationship with the mother. The nurse sets a higher standard of nursing by being there with the patient to deliver safe and effective care, which creates the potential for healing. Within this framework, the nursing professional has to nurture a caring awareness as an essential tool to the healing process, requiring self-development and ongoing personal growth.

Jean Watson's 10 Carative/Caritas Factors

1. Practicing loving-kindness and equanimity within context of caring consciousness
2. Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being cared for
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship
5. Being present to, and supportive of the expression of positive and negative feelings
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated
9. Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care
10. Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared for "allowing and being open to miracles."

(Watson, 2008, p. 34)

Swanson's Theory of Caring

According to Swanson's Theory of Caring (1993), nursing care is viewed as a set of caring processes that are shaped through interactions between patients. The process includes maintaining belief (nurse's philosophical attitudes toward people), and knowing, which involves

trying to understand the loss from the bereaved mother's point of view and using this information to implement interventions which will be relevant and effective in promoting well-being after the loss. "Being with" is providing the emotional presence, support and connection to the patient during a perinatal loss. "Doing for" involves comforting the bereaved mother, anticipating her needs, protecting her from harm, being an advocate, and preserving her dignity during the loss and her bereavement experience. Enabling involves assisting, informing, explaining, providing support, offering feedback, and helping the bereaved mother to focus on important issues during the bereavement process. This theory speaks of the nurturing and attentive caregiver who uses the caring processes to enhance the well-being of the bereaved mother that has suffered a perinatal loss (Hutti et al., 2016, p. 19).

Literature Review

The death of an infant is a catastrophic loss for any parent. "Pregnancy loss is unique among losses and often leaves the woman who experiences it grieving and feeling helpless and hopeless. Of all pregnancies in the United States, 15% to 25% end in fetal loss or spontaneous miscarriage, which has been recognized as the most common complication of pregnancy" (Johnson & Langford, 2015, p. 492). Pregnancy loss is a traumatic event that requires individualized care given with support and sensitivity. This should be done in a safe environment created by attentive healthcare professionals to promote well-being, positive memories, and guidance in navigating through the grief process, thus leading to recovery and eventual resolution of grief.

Healthcare professionals who fail to provide this unique care and support to the bereaved mother can prolong the grief and pain, which can be detrimental to her successful progression

through the normal bereavement process. The professional nurse must have an awareness of the importance of validation and recognition and its significance to the bereaved mother. After the delivery, the postpartum period following a perinatal loss can be particularly difficult for the bereaved mother as it involves her working through both emotional (baby blues, postpartum depression) and physical (recovery and pain from the delivery) changes. A full term fetal demise can be emotionally catastrophic because it is an unnatural act that shatters the existing attachment that has developed over the course of the pregnancy between the mother and developing fetus.

It is essential for healthcare organizations to develop programs to guide bereaved parents in their expression of grief through evidence-based interventions and to encourage them to engage in rituals from their particular religious, cultural, or ethnic background. Johnson and Langford (2015) conducted a study, which supports evidence that structured bereavement interventions implemented immediately following a perinatal loss can support the bereaved mother working through the grieving process and help prevent further despair. Immediate intervention together with follow-up support counseling is the best approach to help in the emotional healing of the mother who has suffered an unplanned full term fetal demise. Healthcare professionals must remember that the normal grieving process is ongoing with much fluctuation between phases. Nurses should be able to ascertain which stage of grieving is being experienced by the bereaved mother and then adjust interventions accordingly.

Research literature supports the education of healthcare professionals on grief and the bereavement process parents go through when they experience the unexpected loss of an infant. Knowledge and insight through education can empower nurses to create a caring and trusting relationship with the bereaved mother, which will help determine appropriate and supportive

interventions that provide guidance through the bereavement process. Nursing professionals withholding support and avoiding the bereaved mother's grief can be detrimental to her recovery and wellbeing (Appendix A).

As nurses begin this educational process, there ae some basic tenets of bereavement specifically centered around grieving parents that should be reviewed. These include:

- The bereaved mother faces a difficult journey because of the catastrophic loss and expressing grief is the normal response to such a loss. Unexpressed grief can be devastating and debilitating, and obstruct the road to recovery.
- An attachment has developed between the mother and fetus throughout the pregnancy and healthcare professionals need to understand the intensity of this attachment, the depth of the grief, and the importance of their sorrow over the loss.
- Working with grief can be exhausting and demanding for healthcare professionals. The grief process is ongoing with many fluctuations with the bereaved parent displaying different reactions at various points throughout the process.
- There are no easy ways to deal with grief after a significant loss, there is no one correct way to grieve, and no set time to grieve.
- Healthcare professionals need to know there are no exact or right words when comforting bereaved parents. Caregivers should try to be genuine and show their care and concern when interacting with bereaved parents. The nurse should be comfortable discussing grief and appropriate bereavement interactions with the bereaved parent.
- Bereaved parents need to find ways to create positive memories and use mementos to remember and honor the lost child. Memories are all they have left after the loss.
- Bereaved parents need validation as they go through their grief and attempt the process of healing, recovery and well-being.
- Healthcare professionals should encourage bereaved parents to express their grief; and create a safe place for them, to express their pain, sadness, and anger. Nurses should grieve and mourn with the bereaved parent and be willing to listen.
- Bereaved parents do not want to be avoided, and are usually most grateful for kind expressions and sincere gestures of love and support from friends, family and their caregivers.

- Bereaved parents need to know that the support of family and friends will continue after the busy days immediately following the death and funeral of their child. Parental grief does not completely go away nor is it fully resolved, it continues forever.

(Bramblett, 1991, p. 39).

SECTION III: Methodology

After the unexpected events on the MBU revealed a knowledge gap with the nurses, the focus of the project became clear: the need to develop an education lesson to fill that gap. Through education, nurses acquire clinical skills, develop critical thinking, and are then able to develop a plan of care that is individualized to meet the specific needs of the patient, translating evidence and transitioning it into practice. An application of the Stewart "Plan Do Check and Act" cycle (PDCA) was used to initiate the first steps and description of the quality improvement project (Learn about quality, n.d.).

- Plan: To identify an opportunity…gap in knowledge and to create a plan for improvement…develop an education lesson.
- Do: Test the change on a small scale where results can be observed and measured, presenting the developed education lesson to a small group of nurses and evaluating their feedback to the lesson.
- Check: Evaluate the effectiveness of the lesson.
- Act: If the education lesson worked, implement it on a larger scale, and monitor results.

Once the knowledge gap was identified and the focus of the change to address the gap was selected, the next step in the process of implementing this project involved identification of the appropriate setting and approval. This quality improvement project involves developing an education lesson for MBU nurses caring for patients who suffered a full term fetal demise. Since that was not a common occurrence on the MBU, the NICU was identified as an appropriate site

for the project due to the patient population, experience with neonatal losses and interaction with bereaved parents. A meeting with the NICU nurse manager was scheduled to obtain approval to use the NICU as a setting for the project and to discuss possible candidates for a mentor with the expertise in this area of nursing care.

A meeting with the NICU nurse manager was scheduled to discuss the purpose of the project and the need for a preceptor to carry out implementation of the education lesson on care of the bereaved mother. The hospital chaplain was initially recommended for project preceptor; however, she recused herself stating she is only in the hospital a couple of days a week and would not be readily available. The chaplain shared some written materials used as guidelines and resources when dealing with grieving parents and offered to be a resource of information if needed. Another meeting was scheduled with the NICU nurse manager to discuss additional recommendations for a possible preceptor. After that meeting with the NICU nurse manager, it was evident that the manager's breadth of knowledge of this patient population as well as her access to the unit made her the best candidate for preceptor of the project. The nurse manager works full time, would be readily available and would also provide access to the NICU, staff nurses and resources used to help with bereavement care and support on the unit. The nurse manager agreed to serve as a preceptor for the project and to serve on the Final Scholarly Project committee. In addition to the DNP program director and NICU manager, a faculty member of Seton Hall University comprised this project's final Scholarly Committee.

Phase I: Needs Assessment Process

Recognizing the problem and needs assessment occurred during Phase I of the project. A knowledge gap in caring for a bereaved mother accentuated the need for further education and training to address this deficit in patient care. The objectives of this DNP project are to provide

the opportunity to explore the impact a full term fetal demise has on the mother and to identify the communication skills and appropriate interventions to provide comfort and support to the mother after the loss. The DNP committee was established to help guide the project in this phase: the objectives of the project, working title and proposal were written and approved. The Kellogg's Logic Model (2004) was utilized to help organize the actions, activities and outcomes of the quality improvement project (Appendix B). Education to improve patient care and broadening of nursing knowledge, leading to patient wellbeing will be the focus of this quality improvement project.

The SWOT analysis was used to determine the strengths, weaknesses, opportunities and threats to put into perspective the tasks needed to facilitate and move the implementation of the project forward successfully (Appendix C). Once the potential risks have been identified and analyzed, they need to be ranked in order of priority. Once this is done, the project needs to capitalize on the strengths of the organization to help overcome its weaknesses and exploit all the opportunities available to counter the threats that can bring down the project's success.

Phase II: Obtaining Support from Stakeholders

For any project to be successful, appropriate stakeholder identification support are necessary. The stakeholders for the project included the nurse managers for the MBU and NICU, the bereavement coordinator and educator, and the NICU clinical coordinator. The NICU nurse manager also serves as preceptor for the project. Implementing the developed education lesson in a teaching organization made acceptance of the proposed quality improvement project favorable. Continuing education is part of the values of the organization, and is always supported through incentives such as tuition reimbursement and organizational partnership with multiple colleges and universities to offer more education opportunities to all nursing staff members. Once the

education lesson was developed, it was initially previewed by the stakeholders to emphasize the relevance of the project for the nursing staff.

Phase III: Initial Implementation Steps

The following are samples of interview responses from NICU nurses who interacted with bereaved parents after the loss of their infant:

- A nurse caring for a 24-week-old male infant who was intubated waiting to be extubated and being weaned off his ventilator. The infant was on an apnea monitor with a diagnosis of a bilateral pneumothorax. The mother was on the antepartum unit, and the parents came to visit frequently. The baby's conditioned deteriorated, and a full cardiopulmonary resuscitation was performed on the baby; however, the baby expired. As per the current bereavement protocol on the unit, the parents were taken to the bereavement room and a priest was called to perform the last rites and baptize the baby as per the parent's wishes. Other family members were invited at this time, and the mother was given a memory box with pictures of the baby taken by the NICU nurse. The nurse was very professional and sympathetic with the parents. The nurse stated that it was difficult to interact with the parents because she was never quite sure what the right thing to say was.
- Another nurse caring for a 25-week-old male infant who was septic on antibiotics, who had positive blood cultures and a poor prognosis. According to the NICU nurse, the mother had a flat affect and was being seen by social services. The baby arrested after 48 hours, cardiopulmonary resuscitation was attempted, but the mother requested the staff stop all heroic efforts. This mother was also on the antepartum unit, but she did not visit the baby as much, making it harder for the nurses to interact with her, so they had limited contact with her. After the baby died, the mother was taken to the bereavement room as

well. Unlike the first parents, the mother did not request any additional rituals and did not want to discuss funeral services. The nurse stated that this happens sometimes because of the initial shock the parents experience after the loss; a memory box was created for the mother by the nurse as per protocol and given to her afterwards.

Despite the fact NICU nurses see neonatal demises more frequently than the nurses on the MBU, they stated it was a challenge to interact with the bereaved parents. One of the nurses stated the NICU nurses could also benefit from the education lesson being developed for the MBU nurses. Although there is currently an existing bereavement protocol, there is no formal or structured education given to the NICU nurses for dealing with bereaved parent. It is simply an overview of the protocol steps initiated immediately following a fetal demise on the unit.

During the review of the bereavement protocol, it was evident that most of nurses on the MBU were not aware of an existing bereavement protocol in the hospital for parents who experience the loss of a child. This further demonstrated the need for a structured bereavement plan for all the nurses in the MBU, emphasizing the importance of validating the loss of the child and facilitating a healthy grieving process. The need for validation as well as education requires an assessment of the mother's specific needs to rituals and mementos to help create a positive memory for her which she can look back on at a later date.

Part of the support that is offered to bereaved parents is a support group (Appendix J). The support group meets on the first Wednesday of each month and is overseen by the bereavement coordinator. The parent group offers comfort and support to bereaved parents and allows them the opportunity to interact with other parents who have suffered a similar loss. The group allows the parents the opportunity to express their grief, concerns and feelings over their loss in a safe place. The parents can develop bonds with other parents who know what they are going through

and can provide solidarity and understanding. Permission was obtained from the bereavement coordinator to attend the parents support group and observe the parents' firsthand responses about their perception of the care they received from healthcare professionals following their loss. A compilation of some of the responses include the following.

- "The nurses did their job after I lost the baby, but they did not spend any time with me."
- "They could have spent more time with me and allowed me to express my feelings. I needed someone to listen to me."
- "No information or support referrals were given to me at the time of discharge. I had to seek and find therapy and help on my own."
- "The staff needs to provide some kind of information of what to expect after the loss of an infant, such as sadness and depression….They need to provide support to the mother and father…Give grief/support referrals at time of discharge so the mother can seek therapy/support if she needs it."
- "I remember only one nurse who gave me any information or answered any questions about the NICU nursery"
- "No information was given to me, and it would have been nice to be informed about what is going on"
- "I received no information at time of discharge regarding my loss."
- "No information was given about what to expect…no support group information was given at time of discharge…no one provided any support or comfort…or allowed me the opportunity to ask questions regarding the loss… it is important to given information so they are aware of what is going on"

- "The only thing they did for me was to give me a memory box of my baby…I appreciate that they did that much for me."
- "I would never return to that hospital because of my bad experience there nor would I recommend the hospital to anyone I know because of the experience I had."
- "It is very important to provide information to the parents when something like this happens…the staff should take the time to answer the parent's questions and provide them with some kind of support afterwards."
- "I remember everyone was very quiet, and the nurses did not really speak to me much…I was left mostly alone."
- "Although everyone was nice enough, they all seemed uncomfortable and avoided eye contact with me…the nurses continued doing their job but I never really felt comforted or supported."
- "I do not remember getting any information during my stay regarding my loss or what to expect after my loss."
- "I understand that this is a difficult and sad situation but showing a little compassion would have been nice to see…It was a very sad time for me and my husband but we felt all alone in our experience…the staff should provide information to the patient regarding a loss during their stay in the hospital, especially if this is your first time experiencing something like this."
- "My experience was a very sad experience."
- "The nurses did not spend any time with me, I felt they were avoiding me…and left me alone most of the time."

- "I did not get any information during my hospital stay about what happened to me or my baby…and my husband and I were never asked questions or given the chance to ask any questions or get any information."
- "This was a very difficult time for us when we lost our baby…we never expected this to happen, since I had a normal pregnancy with no problem…but after it happened, we felt very alone because no one gave us support."
- "It is very important to support the parents when this happens, and nurses should be willing to give information and answer questions because this helps the parents deal with what is happening."
- "I was treated very rudely and indifferently from the moment I came in through the emergency room department…no one gave me any information or answered my questions"
- "I only remember one nurse who took the time to explain anything to me when this happened. She was the only one who gave us any information from the moment we walked in through the entire hospital stay, except for that one nurse who was considerate with me and my husband."
- "This was a horrible experience and I would not like anyone else to go through it, the staff must be there for the patient when such an unexpected loss happens…they must be treated with respect… a loss is a loss, regardless of how far along the pregnancy is!"

Review of the responses emphasized that similar responses were being verbalized by most of the bereaved mothers. Interestingly, these women did not know each other and were of different ages, ethnic and economic backgrounds. Their losses occurred during different stages of pregnancies, yet they all shared the same experience-loss of an infant. The mothers all

experienced similar grief reactions from their loss and expressed disappointment in their interaction with nurses and nursing care.

Response Summary and Commonalities

- This was the first pregnancy and/or first loss for the mothers.
- The mothers did not feel they received enough comfort or support from the nursing staff, and wished the nurses had spent more time with them after they experienced their loss.
- The mothers were not given the opportunity to ask questions.
- No information was provided during their hospital stay regarding their loss and/or what to expect afterwards (about the grief and bereavement process).
- The mothers weren't asked about any spiritual or cultural rituals they might have wanted.
- The nursing staff was perceived as indifferent, unsupportive and at times avoiding the parent after the loss.
- The mothers agreed the nurses did their job/tasks/and duties during the patient's stay, but made no extra effort.
- The mothers expressed a feeling of isolation after the loss.
- No information about support groups, mental health therapy/support or crisis intervention was provided at time of discharge, this was a very essential component for all of them.

Simple interventions could have dramatically changed these mothers' perceptions of care provided to them; moreover, some simple changes in attitude and message delivery could have positively impacted these mothers' emotional states. By spending uninterrupted time, encouraging questions and expression of feelings, providing comfort and support after the loss, and most importantly offering referral information, nurses could provide bereaved mothers with much needed support. Also, by receiving this from the nursing staff, these actions would make an already difficult and painful event more tolerable and less stressful for these mothers. It would have also prevented creating negative memories to an already traumatic experience.

Phase IV: Ongoing Implementation Process

Hospitals providing care for patients based on their needs for prevention and treatment of illness, rehabilitation for injury, and education. As with any business, hospitals' performance is evaluated by these patients through customer satisfaction surveys that measure their perception of their care and hospital experiences. These survey results serve as incentive to work on problematic areas as well as find solutions to improve quality of care. Literature supports educating nurses on the grief and bereavement process of bereaved parents. This education furnishes insight that empowers nurse to be advocates for bereaved mothers to help them through the bereavement process by choosing appropriate interventions that give support, comfort and the guidance needed after suffering a devastating loss. Bereaved parents will recall small acts of kindness, but they will also remember insensitive comments, actions, behaviors, and/or avoidance of the parent for years to come, perhaps for even a lifetime.

An education plan was developed for MBU nurses using the evidence-based practices supported by literature; interviews with the NICU nurses and the existing bereavement protocol in the organization were used during this process (Appendix E and F). The education lesson was initially shown to a small group of nurses from the MBU, the NICU nursery, and labor and delivery. They were given an evaluation form that was developed (Appendix G) to complete after viewing the lesson to give the nurse the opportunity to provide feedback on the relevance of the lesson content and what they learned from the lesson.

In addition to the lesson, an accompanying education pamphlet was created highlighting the key points from the lesson to be given to the nurses to use for future reference (Appendix H). Expansion of the initial implementation of the nursing education lesson to larger groups of nurses from the MBU will occur in this phase. The lesson will be shown to small groups of staff nurses in the upcoming weeks and months until all the nurses from the unit and all shifts can

view the education presentation. The evaluation forms will be collected from the participants after viewing and reviewed for feedback on the relevance of the lesson plan as well as any recommendations for improvement.

Phase V: Project Evaluation Process

The project evaluation process included discussions with the stakeholders after viewing the education slide presentation. The recommendations and suggested changes from the stakeholders were incorporated into the education lesson prior to MBU nurse screening. Stakeholder support of the education lesson content validated the presentation as valuable to the unit and to the MBU staff nurses, who were the targeted learners. The evaluation given to nurses after they viewed the lesson provided reinforcement that the lesson met the teaching objective. The evaluation also gave the nurses the opportunity to assess the value of the information being offered in the lesson and gave them a voice to make recommendations or changes that would benefit them in the future, when caring for bereaved mothers.

Nurses' Evaluation Feedback

- The nurses found the information very informative.
- The majority of the nurses expressed surprise that avoiding the parent and giving them space was a negative action in the eyes of the mother.
- They learned about appropriate "approach" to a mother of a fetal demise.
- Many nurses expressed uncertainty in what to say or do when caring for a bereaved mother and felt the lesson helped guide them for future reference.
- The nurses liked the structure and organization of the information in the power point presentation.

- The nurses expressed feeling more comfortable and confident if they should find themselves in the situation of having to care for a bereaved mother.
- The nurses expressed gratitude to the author for presenting them with this new knowledge.

Positive feedback from nurses provided validation of this quality improvement project as being significant to nursing. Change can often be met with resistance. Nurses being supported by stakeholders and administration during the implementation process helped to reduce the fear, stress, and resistance to change. For evidence-based practices to be most effective, a supportive environment is needed that not only encourages change but promotes and supports research and the use of research to maintain current with the best evidence-based practices. From its inception, the proposal prioritized the need for further education and training of MBU nurses to meet the demand of improving care delivery for the bereaved mother. Project evaluation helps determine the effectiveness of the education plan by reviewing if the project objective of preparing the nurse to provide appropriate care and support of the bereaved mother has been met.

Section IV: Project Sustainability and Recommendations

Project Sustainability

In keeping with the organizational core values, which embrace continuing education, and keeping relevant with the best evidence-based practices to ensure quality patient care, this project was developed to be reproducible and sustainable. Upon reviewing the lesson, the bereavement coordinator recommended that it should complement the bereavement segment that was offered as part of the yearly nursing skills competency (Appendix I) that is mandatory for all nurses in the maternal child division, and upon completion, the lesson completion would be filed in all the nurses' employee records. The educational content can readily be reproduced and can be easily

incorporated into the existing organizational education protocols such the yearly nursing skills competency fair. It was also suggested that the lesson could become part of the new hire orientation process provided to all onboarding maternal-child nurses when they start working in the hospital. These existing formats provide not only ongoing future sustainability, but a yearly update of bereavement practices. By instituting bereavement education for all health care professionals who provide care for patients who have experienced perinatal loss, the organization ensures appropriate delivery of care for improving practice.

Recommendations

During conversations with the bereavement coordinator, the future recommendation for the formation of a bereavement team was discussed as being a beneficial component for the care of the bereaved mother and the nurses who care for them. Literature supports the development of a bereavement team to help an organization keep current with bereavement practices and interventions. The bereavement team would be comprised of interdisciplinary members from the units that are directly affected by a perinatal loss: the MBU, the antepartum unit, labor and delivery unit, and NICU. The bereavement team would work collaboratively with staff nurses to ensure they have the support needed to provide competent care to bereaved mothers immediately following their loss. The team would also provide nurses the opportunity to debrief after caring for such a vulnerable patient during a very difficult and stressful time. Debriefing as a stress management and coping technique is supported by literature to help provide support for nurses caring for bereaved mothers. These sessions allow review of the traumatic event (death of an infant), discussion of thoughts, and reflection on the emotional toll and impact of the loss on the nurse.

Through a structured bereavement protocol, healthcare professionals can ensure that bereaved mothers receive nursing care that is clinically competent, emotionally intelligent, consistent and authentically caring. Bereaved mothers are among the most vulnerable patients in the care of maternal-child nurses. Nurses can make their interventions provide meaning to the loss, help create positive memories, and facilitate healing in the midst of a difficult situation ensuring the bereaved mother has the healthiest experience possible to promote wellbeing (Downe et al., 2012).Providing this level of care will fulfill the unique needs of the bereaved mother by creating a safe environment and trusting relationship. Nurses should be given increased education to help recognize the importance of their role in a perinatal loss and understand how their behaviors and actions can have a profound impact on the bereaved mother. Guiding bereaved mothers through a perinatal loss is an essential component of caring for patients and contributes to the normal grieving process and recovery. Although no one can take away the grief or pain of losing a baby, trained nurses can potentially reduce the traumatic effects immediately following the loss. Bereaved parents appreciate actions from healthcare professionals that demonstrate emotional support and show attention to the specific needs of the mother immediately following a perinatal loss.

References

Ainsworth, M. D. S. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development*, 40(2): 969-1025.

Arnold, J., Gemma, P.B. (2008). The continuing process of parental grief. *Death Studies*, 32:658-673.

Bartellas, E. & Van Aerde, J. (2003). Bereavement support for women and their families after stillbirth. *Journal of Obstetrics & Gynaecology Canada*; 25(2): 131-8.

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing*, 25(1):1–10.

Bowlby, J. (1969). *Attachment and loss: Attachment*. New York, NY: Basic Books.

https://whatsyourgrief.com/bowlby-four-stages-of-grief/

Bramblett, J. (1991). *When good-bye is forever: Learning to live again after the loss of a child.* New York: Ballantine Books.

Bretherton, I. (1992). The Origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28(4):759-775.

Carter, L. (2016). Understanding our role in bereavement. *International Journal of Childbirth Education*, 31(4): 28-30.

Caruso EM1, Cisar N, Pipe T. (2008). Creating a healing environment: An innovative educational approach for adopting jean watson's theory of human caring. *Nursing Administration Quarterly,* Apr-Jun; 32(2):126-32.

Christ, G.H., Bonanno, G., Malkinson, R., and Rubin, S. (2003). Bereavement experiences after the death of a child. NCBI bookshelf. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK220798/

Downe, S., Schmidt, E., Kingdon, C., and Heazell, A.E.P. (2013). Bereaved parents' experience of stillbirth in uk hospitals: A qualitative interview study. *British Medical Journal Open,* 3(1): 1-10.

Garstang, J., Griffiths, F., and Sidebotham, P. (2014). What do bereaved parents want from professionals after the sudden death of their child: A systemic review of the literature. *BMC Pediatrics,* 26(14): 11-17.

Gold, K.J. (2007) Navigating care after a baby dies: a systematic review of parent experiences with health providers. *Journal of Perinatology*, 27(3): 230–237.

Guzman, I. (2018). Appendix education lesson slides, *Caring for the bereaved mother*. Unpublished manuscript, Seton Hall University.

Guzman, I. (2018). Appendix evidenced based interventions, *Caring for the bereaved mother*. Unpublished manuscript, Seton Hall University.

Guzman, I. (2018). Appendix bereavement pamphlet, *Caring for the bereaved mother*. Unpublished manuscript, Seton Hall University.

Guzman, I. & Giddens, S. (2018) Appendix parents' bereavement support group, *Caring for The bereaved mother.* Unpublished manuscript, Seton Hall University. Adapted with persmission from www.stjosephshealth.org.

Guzman, I. & Marut, M. (2018). Appendix perinatal skills fair competency form 2017, *Caring for the bereaved mother*. Unpublished manuscript, Seton Hall University. Adapted with permission from www.stjosephshealth.org.

Hutti, M.H., Polivka, B., White, S., Hill, J., Clark, P., Cooke, C., Clemens, S., and Abell, H. (2016). Experiences of nurses who care for women after fetal loss. *Journal of Obstetric, Gynecologic, & Neonatal Nursing,* 45(8), 17–27.

Johnson, O. P.,& Langford, R. W. (2015). A randomized trial of a bereavement intervention for pregnancy loss. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, Jul-Aug, 44(4): 492-499.

Jonas-Simpson, C. M., Watson, J., McMahon, E., & Andrews, L. (2010). Nurses' experiences of caring for families whose babies were born still or died shortly after birth. International *Journal for Human Caring*, 14(4):14–21.

Kelloggs logic model (2004). Adapted with permission from the *W.K. Kellogg Foundation Logic Model Development Guide.*

Koloroutis , M. (2004). Relationship-based care: A model for transforming practice. Minneapolis, Minnesota: Creative Health Care Management.

Leask Capitulo, K. (2005). Evidence for healing interventions with perinatal bereavement. *Maternal Child Nursing*, Vol. 30(6): 389-396.

Limbo, R., & Kobler, K. (2010). The tie that binds: Relationships in perinatal bereavement. *American Journal of Maternal Child Nursing*, 35(6): 316-31.

Malacrida, C.A. (1997). Perinatal death: Helping parents find their way. *Journal of Family Nursing*, 3 (2): 130-48.

Marckx, B. (1995). Watson's theory of caring: A model for implementation in practice.

McLeod, S. (2007). Bowby's attachment theory. Retrieved https://www.simplypsychology.org /bowlby.html

McGuinness, D., Coughlan, B., and Power, S. (2014). Empty arms: Supporting bereaved mothers during the immediate postnatal period. *British Journal of Midwifery*, 22 (4): 246

Clinical Midwife Specialist (Bereavement), National Maternity Hospital, Holles street, Dublin 2 *Journal of Nursing Care Quality*, 9(4): 43-54.

Puia, D. M., Lewis, L., & Beck, C. T. (2013). Experiences of obstetric nurses who are present for a perinatal loss. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 42(3): 321-331.

Rosenbaum, J.L., & Smith, J.R. (2011). Neonatal end-of-life spiritual support care. *Journal of Perinatal and Neonatology Nursing*, 25(1): 61-69.

Sousou, J., & Smart, C. (2015). Care of the childbearing family with intrauterine fetal demise. *Nursing for Women's Health*, 19 (3): 236-47.

Swanson KM. (1991). Empirical development of a middle range theory for caring. *Nursing Research*; 40:161–166 [PubMed].

Swanson, K.M., Chen, H.T., Graham, C., Wojnar, D.M., & Petras, A. (2009). Resolution of depression and grief during the first year after miscarriage: A randomized controlled clinical trial of couples-focused interventions. *Journal of Women's Health*, Vol 18 (2): 1245-1257.

Swanson, K. M. (1999). Effects of caring, measurement, and time on miscarriage impact and women's well-being. *Nursing Research*, 48(6): 288–298.

Swanson, K. M. (1993). Nursing as informed caring for the well-being of others. *Image: Journal of Nursing Scholarship*, 25(4): 352–357.

SWOT analysis (n.d.). Retrieved from https://www.learning-theories.com/swot-analysis.html.

Van Aerde, J. (2001). Guidelines for health care professionals supporting families experiencing a perinatal loss. *Paediatrics & Child Health*, 6 (7): 469-477.

Watson, J. (2008). Nursing: The Philosophy and Science of Caring (rev. ed.), Boulder: University Press of Colorado.

Watson, J. (2006). Watson's theory of human caring and subjective living experiences: Carative

factor/caritas processes as a disciplinary guide to the professional nursing practice. *Danish Clinical Nursing Journal*, 20 (3): 21-7.

Watson, J. (2006). Caring theory as an ethical guide to administrative and clinical practices. *Nursing Administration Quarterly*, 30(1): 48–55.

Watson, J. & Smith, M.C. (2001). Caring science and the science of unitary human beings: a trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing*, 37(5): 452-61.

Watson, J. & Foster, R. (2003). The attending nurse caring model: Integrating theory, evidence and advanced caring–healing therapeutics for transforming professional practice. *Journal of Clinical Nursing*; 12: 360–65.

What's Your Grief. (n.d.). Before the five stages were the four stages of grief. Retrieved from https://whatsyourgrief.com/bowlby-four-stages-of-grief/

Wright, P. M., & Hogan, N. S. (2008). Grief theories and models: Applications to hospice nursing practice. *Journal of Hospice & Palliative Nursing*, 10(6): 350–356.

www.bereavementservices.org

Appendix A

Healing Practices and Rituals in the Care of Bereaved Families

Presence:
- Facilitate the presence of loved ones, family, children, and friends.
- Offer your own presence.

Communication:
- Inform the mother/family of what will happen (do not be silent).
- Encourage/facilitate mother/family to "tell their stories."
- Give results of tests/autopsy in person.

Memories and Mementos:
- Seeing baby: Viewing (can be in office, chapel, house of worship, or funeral home)
- Do not limit time
- Photographs: instant and portrait
- Memory boxes
- Locks of hair
- Name bracelets
- Foot/hand prints and casts
- Name certificate
- Journals
- Quilts of the baby's clothing

Rituals:
- Naming
- Spiritual blessing/baptism
- Viewing (can be in office, chapel, house of worship, or funeral home)
- Memorial service
- Religious rites
- Burial
- Balloon release

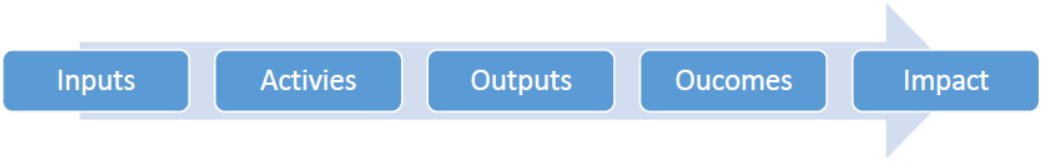
Support Groups

Holidays:
- Encourage families to make their own decisions about how to celebrate holidays, not allowing others to tell them what do to
- There is no right or wrong, some may follow family traditions, and some not.
- Keep in mind the feelings of children and family; try to make it joyous for them.
- Don't avoid the hurt.
- Shop in the middle of the night, there are fewer people.
- Set limits.
- Get enough rest.
- Use symbols and photos of your loved one to decorate for the holiday.
- Incorporate memories and mementos into holiday rituals.
- Change traditions that year:
- If you celebrate Christmas, buy a tree if you used to cut one.
- Visit others, take a vacation.
- Change the time/location of dinner.
- Attend religious services at a different place.

(Leask Capitulo, 2005)

Appendix B

KELLOG'S LOGIC MODEL



Resource nurse	Nursing in-service on parental bereavement	Nurses educated in parental bereavement plan of care	Increased nursing awareness of bereavement	Interdisciplinary team providing quality care to parent
Nursing staff	Patient education using teaching sheet	Parent education completed at discharge	Increased nursing knowledge of care of bereaved parent	Increased patient satisfaction scores
Written materials: patient education pamphlets	Physician and resident and medical student in-services	Medical staff support	Increased patient quality of care	Culture change in dealing with bereaved parents
Social Services	Parent support group	Parent referrals provided	Increased parental support	Positive support for bereaved parents
Pastoral care services				Increased hospital satisfaction scores

Your Planned Work	**Your Intended Results**

Kellogg's logic model. Adapted with permission from the *W.K. Kellogg Foundation Logic Model Development Guide (2004).*

Appendix C

SWOT Analysis

Strengths	**Weaknesses**
What advantages does your organization have? ▪ We are a Magnet organization which emphasizes our excellence in nursing care. ▪ The organization is very competitive and wants to keep abreast of latest developments in patient treatment and care. ▪ Strong organization mission to always provide the best possible care to all its patients. ▪ Shareholders who are open to change that can bring quality improvement to patient care and improved patient satisfaction. What do you do better than anyone else? ▪ We are a teaching organization that encourages all employees in continuing education. ▪ The organization strives to use best evidence based practice (EBP) that can improve the care and service it provides to its patients. ▪ It is a children's hospital with a Level II Neonatal Intensive Care Nursery. What unique or lowest-cost resources can you draw upon that others can't? ▪ The organization has an in house continuing education department, so it does not have to hire outside instructors/educators when making an in house change to patient care ▪ In house printing department for printed educational materials for patients. What do people in your market see as your strengths? ▪ The friendliness of hospital staff. ▪ The nursing care provided to patients (Magnet recognition for nursing excellence)	What could you improve? ▪ There is always room for patient care improvement and continued education in nursing. ▪ Patient practices should always be reviewed to ensure they are up to date and the best EBP to improve the quality of the patient care provided. What should you avoid? ▪ Change in practices that have not been researched completely. ▪ Change in practice that may not be practical or cost effective to implement. ▪ Just because something sounds great for another organization does not necessarily mean it will work in our organization…it is important to always keep site of our core population and the community the organization services. What are people in your market likely to see as weaknesses? ▪ The logistical location of the organization is always looked at as a weakness, because it is an inner city hospital. ▪ The majority of the patients are of low socioeconomic status, with little or no health insurance. What factors lose you sales? ▪ Location, location, location
Opportunities	**Threats**
What good opportunities can you spot? ▪ Using the organizational strengths to help bring about the necessary change. ▪ The shareholders past history of openness to positive change. ▪ An organization that is not afraid to grow and encourages growth through continuing education. What interesting trends are you aware of? ▪ Nursing trends that provide building blocks to an interdisciplinary team that includes the patient, family and patient care givers. ▪ Patient centered care. Useful opportunities can come from such things as: ▪ Changes in technology and markets on both a broad and narrow scale. ▪ Changes in government policy related to your field. ▪ Changes in social patterns and lifestyle changes. ▪ Local community events, that provides health education, health screening and Q & A sessions for healthcare personnel and patients.	What obstacles do you face? ▪ Senior staff that may be resistant to change in policy and care. ▪ Fear of failure. ▪ Resistance from the physicians. ▪ Ethical issues. What are your competitors doing? ▪ The subject seems under-observed in other organizations as well, based on conversations with nursing staff from local surrounding hospitals. Are quality standards or specifications for your job, products or services changing? ▪ Quality standards of my job would be changed with the knowledge of better practice of care for a sensitive population during a difficult time. Is changing technology threatening your position? ▪ No technology change is not a threat but an asset. Could any of your weaknesses seriously threaten your business? ▪ In a time where so many hospitals are closing for business, there is always a threat out there. This organization has stood for 125 years but who knows what will happen in the future. At this time, focus must be on what change and improvements in patient quality of care can be made now at this time for the current patients before us**.** **(Guzman, 2018)**

Appendix D

Existing NICU Bereavement Protocol

Parents and family are taken to the bereavement room on the unit to give them time to spend with the baby and say their goodbyes.
Other family members and /or friends are called at parent's request.
Staff offers to allow siblings if parents so choose, most times they decline because they feel it may be too traumatic for their other children.
Clergy/priest/minister is notified as per parent request; priest is not always on-call, so this can take some time.
Notify social services to help parents with funeral services.
Bereavement counselor is notified.
Sharing Network is notified as per protocol
The morgue is notified within one hour of time of death
Pictures of infant are taken by nurse who was caring for the baby.
Baby is hand and foot printed.
Baby is clothed with articles of clothes in the memory box, if the parent does not take the box at time of death it is delivered after hours.
Pandora bracelet with milestone and butterfly (symbolizing the passing of the baby) made for the mother of baby's 32 weeks or younger.
Support group for parents who experience a loss is given by the case worker to the parents. (Guzman, 2018)

Appendix E

Evidence Based Interventions

What not to say:

- "I know how you feel"
- "Time heals all wounds"
- "You can have more children"
- "It could be worse"
- "It's best this way"
- "It's good your baby died before you got to know him or her well"
- "They are in a better place"

What to say:

- "I'm sorry"
- "I don't know what to say"
- "Do you have any questions?"
- "We can talk again later"
- "I will do whatever I can to help you through this difficult situation"
- "Who can I help you contact (family, friends, priest/minister)"

What nurses should not do:

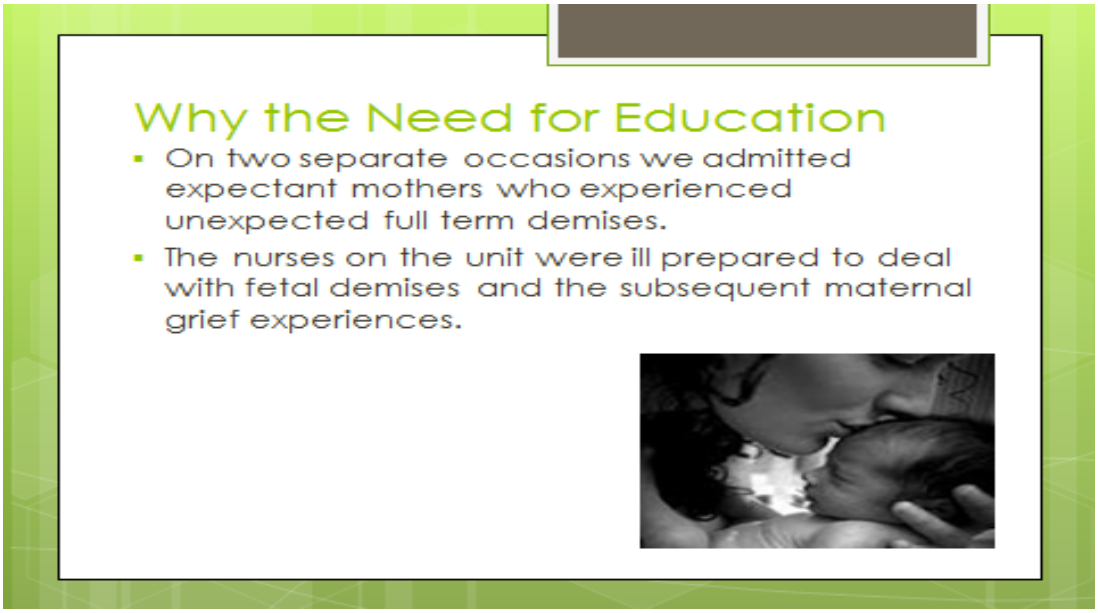
- Avoid the mother or their grief
- Impose your views or feelings on the mother or set limits for them about what is right or appropriate behavior.
- Keep information from the mother because you feel bad.
- Not allow the mother ask questions.
- Be afraid to let the parents cry or to cry with them.

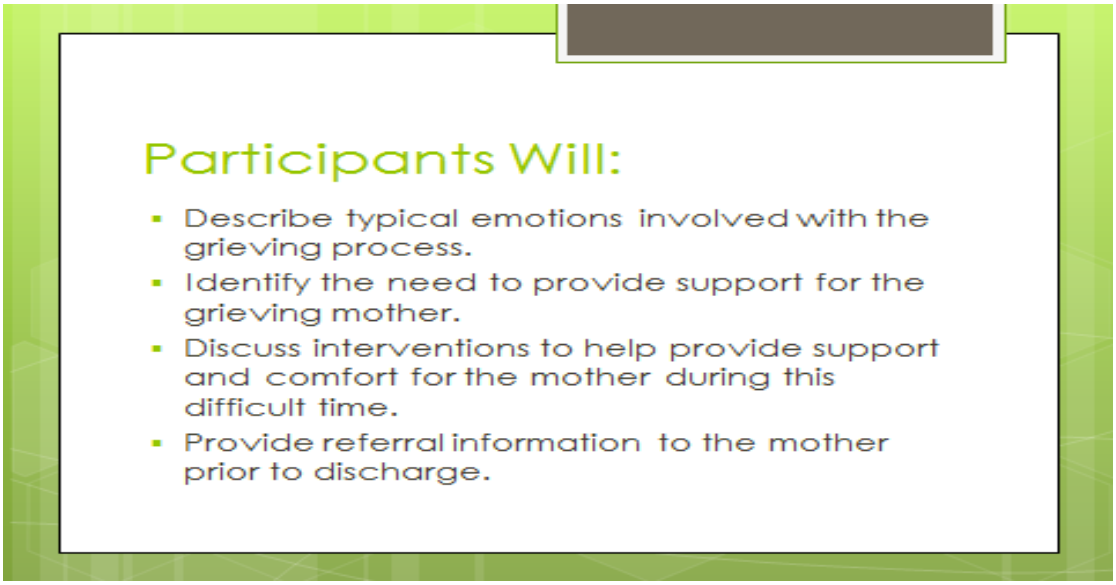
Supportive interventions for nurses to utilize when interacting with the bereaved mother:

- Ensure they respect the individuality of the bereaved mother and offer patient centered care and support.
- Help patient be aware of emotions they may encounter during their grief process.
- Encourage mother to express feelings.
- Acknowledge the loss by telling the mother of your sadness for them, and by expressing support, and try to provide comfort.
- Encourage healthy coping mechanisms.
- Act natural, show genuine care and concern.
- Make it clear that you are there to listen and pay attention.
- Wait for the parents to ask for help or tell you what they need.
- Ensure the mother is seen by social services who can provide further support resources if needed.
- Make sure the mother is given the Edinburgh post-partum depression screening after the loss, prior to discharge, and ensure follow-up with psychiatry if needed.
- Provide referrals (ex: support groups, grief counseling) prior to discharge (Appendix I).
- Arrange follow-up phone call to the mother to check on them and their progress after discharge from the hospital. (Guzman, 2018)

Appendix F

Education Lesson Power Point Slides





(Guzman, 2018)

Appendix G

Education Presentation Evaluation Tool

Presenter: Ivonne Guzman MSN, BSN, RN

Participant: _____

Presentation Title: Caring for the Bereaved Mother

Objective/Goal**:** Provide EBP interventions for nurses caring for the bereaved mother.

Code: **5=Excellent, 4=Good, 3=Fair, 2=Poor, 1=N/A**

1. How well did this continuing education presentation meet your learning needs?
    - 1
    - 2
    - 3
    - 4
    - 5
2. Was the presentation clear, orderly and understandable?
    - 1
    - 2
    - 3
    - 4
    - 5
3. Was the objective of the presentation met?
    - 1
    - 2
    - 3
    - 4
    - 5

4. What did you learn from the presentation that will help you in the future?

    _____

5. What did you like about the presentation?

    _____

6. Additional comments:

    _____

Appendix H

Education Pamphlet (Guzman, 2018)

Grieving

- Disbelief/shock over the loss
- Confusion
- Frustration and anger
- Blaming and feelings of guilt
- Feeling emotional and vulnerable
- Feelings of hopelessness and helplessness

Stages of Grief Cycle

- *Shock & Denial*
  Avoidance
  Confusion
  Fear
  Numbness
  Blame
- *Anger*
  Frustration
  Anxiety
  Embarrassment
  Shame
- *Depression & Detachment*
  Overwhelmed
  Lack of Energy
  Helplessness
  Hopelessness
- *Bargaining*
  Reaching out to others
  Desire to communicate
  Struggle to find meaning for what has happened
- *Acceptance*
  Exploring options
- **Return to Meaningful Life**
  Empowerment
  Security
  Self-esteem/meaning

What to Say

"I'm sorry"
"I don't know what to say"
"Do you have any questions?"
"We can talk again later"
"I will do whatever I can to help you through this difficult situation"
"Who can I help you contact (family, friends, priest/minister)"

What not to Say

"I know how you feel"
"Time heals all wounds"
"You can have more children"
"It could be worse"
"It's best this way"
"It's good your baby died before you got to know him or her well"
"They are in a better place"

How Can You Help The Grieving Mother?

- Be a good listener
- Just sit with them
- Ask about their feelings
- Share your feelings
- Acknowledge their pain
- Be available to the mother
- If you don't know what to say, that's okay…and share that you don't know what to say

Memories/Mementos

- Viewing baby in a private area/space (do not limit their time with baby)
- Photographs: instant and portrait
- Memory boxes
- Locks of hair
- Name bracelets
- Foot/hand prints and casts
- Name certificate
- Journals
- Quilts of the baby's clothing

Caring for the Bereaved Mother

Parental grief is felt as a deeply personal and unique response to the death of a child yet bereaved parents are joined by their experience, which is unparalleled and known only to them in ways that cannot be easily communicated to others (Arnold & Gemma, 2008).

Appendix I

Perinatal Skills Fair Competency Form 2017

Name:_____Date:_____

Unit:_____ Employee ID #_____

Methods of Competency Validation: DO=Direct Observation C=Chart Review V=Verbalizes T=Test

Hand Hygiene

Objective: To wash or sanitize hands according to the standard of care	**Method**	**Met**	**Not Met**
1. Wet hands and wrists with warm water, and apply soap from a dispenser. Keeping hands below elbow level	**DO**		
2**.** Work up a generous lather by rubbing hands together vigorously for at least 20 seconds. Pay special attention to the areas under fingernails and around cuticles as well as to thumbs, knuckles, and sides of fingers and hands. If ring is not removed, move it up and down fingers to clean beneath them	**DO**		
3**.** Avoid splashing water on self and the floor or touching the sink and faucet	**DO**		
4. Rinse hands and wrists well. Pat hands and wrists dry with a paper towel. Turn off the faucets by gripping them with a dry paper towel	**DO**		
5. Apply alcohol-based hand rub to the palm of one hand and then rub hands together covering all surfaces of hands. Continue rubbing hands together until the product has dried	**DO**		
6. Identify situations when the use of hand sanitizer is inappropriate	**V**		

Restraints

Objective: To demonstrate the appropriate and safe use of restraints for non-violent or non-self-destructive behavior	**Method**	**Met**	**Not Met**
1.Demonstrate the proper application of restraints using a quick release knot	**DO**		
2.Discuss the procedure of ordering restraints	**V**		
3.Identify restraint alternatives	**V**		
4.State the frequency and list components of the assessment of a patient with restraints in use in accordance with SJHS policy	**V**		

Newborn Metabolic Screening

Objective: All newborns will have a screening for metabolic disorders prior to discharge as per NJDOH Guidelines using correct technique & documentation	**Method**	**Met**	**Not Met**
1. Identify the proper site and technique for appropriate specimen collection	**V, DO**		
2. Discuss correct documentation on NJDOH lab slip	**V**		
3. Explain the patient specific time frames for specimen collection	**V**		

Infant Safety/Prosec

Objective: Prosec® security system is applied and used in accordance to manufacturer guidelines and SJH	**Method**	**Met**	**Not Met**
1.Demonstrate correct procedure for preparing and applying transponder/tag	**DO**		
2.Demonstrate correct procedure for removing, cleaning, and storing tag	**DO**		
3. Discuss the correct process regarding admit, edit, transport, return from transport, and discharge of patients with Prosec ® tag	**V**		
4.Describe the difference between a "Warning" & an "Alarm"	**V**		
5.Identify the steps to follow in the event of an "Alarm"	**V**		
6.Discuss correct procedure for using the Pocket Tag Tester	**V**		
7.Discuss correct procedure for utilizing the bypass keypads	**V**		

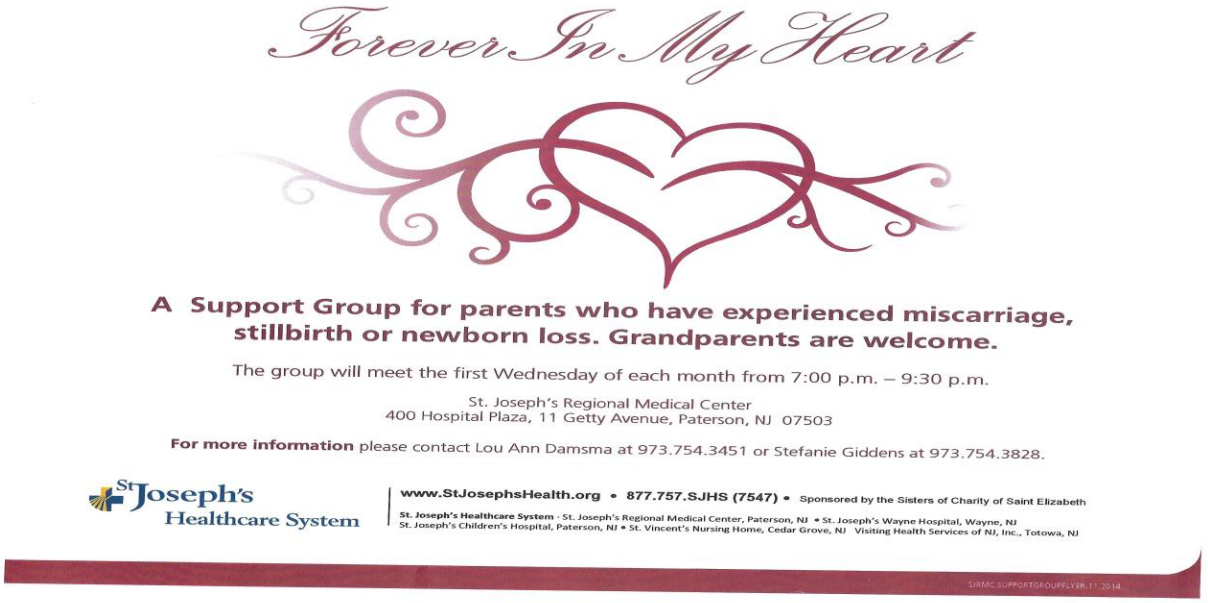
Perinatal Bereavement

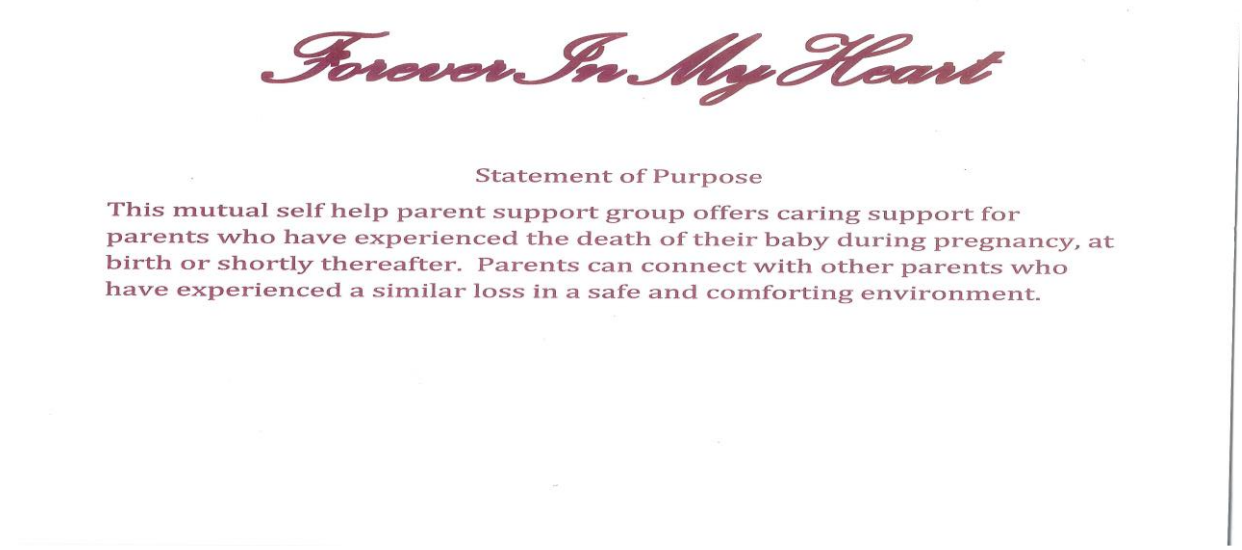
Objective: Displays knowledge regarding the unit specific policy pertaining to perinatal Bereavement	**Method**	**Met**	**Not Met**
1.Describe the Bereavement Packet	**V**		
2.Identifies the post-delivery bereavement process for assigned unit	**V**		
3. Discusses post-mortem care i.e. ID bracelet, wrapping, morgue transport, pastoral care notification, burial/disposition consent	**V**		
4.Explain differences between < or > 20 week gestation loss.	**V**		

(Adapted with permission from www.stjosphsheath.org.)

Appendix J Parents Support Group

. Adapted with permission from www.stjosphsheath.org.





Appendix K
Bereavement Support Referrals

- **H.O.P.I.N.G:** Free informal ongoing support group for grieving parents.
  The group meets the third Monday of every month from 7-9pm.
  Virtua Health-West Jersey Voorhees, Barry Brown Health Education Center
  106 Carnie Blvd., Voorhees, NJ 08043
  1-888-VIRTUA-3

- **Guardian Angel Perinatal Support Group (GAPS):** Free informal ongoing support group for bereaved parents. The group meets the first Friday of each month from 7:30-9:30pm.
  St. Kilian Parish Center
  485 Conklin Avenue
  Farmingdale, NY 11735, Media Room

- **M.I.S.S.** Mothers In Sympathy & Support
  Coordinator Joanne Caciatore (623) 979-1000
  The M.I.S.S. Group Locator

- **SHARE Pregnancy & Infant Loss Support of North New Jersey**
  973-543-2495, email: sharenonj@msn.com. Non-denominational, national organization formed by and for parents grieving the death of a baby. There are monthly group meetings, a lending library, phone-pals, and newsletter. All welcome.

- **Compassionate Friends:**This organization has many local chapters and offers grief support groups. These groups, specifically for parents who have lost a child, meet approximately once a month
  Phone: (630)-990-0010
  Fax: (630)-990-0246
  www.compassionatefriends.org.

www.shareatlanta.org

www.bereavementservices.org

www.storknet.com/cubbies/pil/mem.html