Guidelines to supporting mothers with pregnancy loss at a public hospital in South Africa

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Abstract: Although the general topic of death is receiving increasing attention from the medical community, little is known about the impact that pregnancy loss has on the lives experiencing it. The purpose of this study is to develop guidelines for mothers with pregnancy loss. This research is a qualitative research design that is exploratory, descriptive and it is contextual in nature. The guidelines was formulated from the information gathered from phases I; II; and III. The guidelines were validated and recommendations were made by experts. Phase I phenomenological interviews were conducted with ten mothers on how they experienced pregnancy loss and care. Phase II focused on semi-structured individual interviews which were conducted with seven medical doctors and ten midwives on their experience. Phase I and II were in this study and both were published in Health South African research journal: June 2007.
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1. Introduction

Pregnancy loss is a prevalent and potentially life-transforming event for bereaved parents and their families. More often than not, however, parents do not receive appropriate care even though widespread consensus on care and support exists in the literature and among professionals in the field (Lang et al 2005). According to Mander (2003) the midwife is in the privileged position of being able to be with the woman when she first faces such losses. It is the responsibility of the midwife to draw on her theoretical knowledge which, as in any area of her care, should be based as far as possible on the skilled care of the woman to assist her adjustment to these losses. The trauma of prenatal loss can have long-term effects on the family. From the empirical findings in phase I and II of this study, it emerged that support was needed by both mothers with pregnancy loss, and health workers in the maternity section.

The mothers with pregnancy loss need support from the health workers but, unfortunately, the health workers are overwhelmed by the stresses of the working environment and lack the knowledge and skill to give those mothers an appropriate support. The difficulty that the staff faces in caring for a grieving mother has been linked with their own personal reactions to the loss of a baby (Mander, 2003). This may be part of the reason for the long-standing neglect of such mothers. Furthermore, the loss of a baby may represent all too clearly failure of the health care system, and those who work in it, to provide the mother with a successful outcome to her pregnancy. The fear of failure in turn engenders a cycle of avoidance, which perpetrates the neglect of the mother. From the magnitude of this problem and after analysis of the data in phases I and II, the development of guidelines to support mothers with pregnancy loss was recommended. The aim of these guidelines is to develop knowledge and skills for the health worker to empower and enable them to support mothers with prenatal loss. So health workers need stress management training and the knowledge and skills to enable them to support the mothers with pregnancy loss so they can be expected to function. The research project was carried out in four phases. Phases 1 and II dealt with the experiences of mothers with pregnancy loss; how the mother with pregnancy loss experienced the care given by midwives and doctors; and the experiences of midwives and doctors when caring for mothers with the loss. Phase III dealt with concept analysis. The objective of this phase was to analyze and conceptualize the central concept 'support'. From the empirical data the main concept of support was identified, analyzed and described. Phase IV dealt with the development of guidelines in order to assist midwives and doctors to support mothers with pregnancy loss.

2. Research design and methods

A qualitative research method, which is analytical, descriptive and contextual, was used to reveal the type of support needed and development of the guidelines for mothers with pregnancy loss (Mouton, 1996; Mouton and Marais, 1990). The research method was discussed by using phases. Phase III involved the description and analysis of the main concept of support, which helped the researcher to clarify the appropriate type of support needed for mothers with pregnancy loss. The purpose of this study was to develop and describe guidelines to assist

midwives and doctors to support mothers with pregnancy loss. The following specific objectives were formulated and met:

- To analyze the concept of 'support'
- To describe the support programme to assist the midwives and doctors to support the mother with prenatal loss.

From Phases I and II, it became clear that there was a desperate need for rendering support to both midwives and doctors in the form of stress management, and for equipping them with knowledge and skills to be able to support mothers with pregnancy loss. All doctors and midwives who were interviewed described their experiences when caring for mothers with pregnancy loss. Some shared the same experiences, but some did not. The midwives (nurses) and doctors in the maternity unit had to deal with certain external factors that they could not control, which then led to feelings of frustration and disempowerment, for example, increased workload and staff shortages. These factors meant that there was not enough time to give each mother adequate attention.

Implementation of strategies

The researcher is an advanced midwifery practitioner implementing the strategies which were viewed as best for the needs and problems of both the mother and the health worker. With the appropriate managerial skills it was ensured that all the necessary strategies were being applied and planned well. In this study, the advanced midwifery practitioner regarded it as necessary to start the implementation of these strategies with the health worker first, so that they could give the necessary support. Therefore it was ensured that the health worker possesses the necessary skills and knowledge related to supporting the mothers with prenatal loss. After evaluation of the strategies implemented with the health worker, the advanced midwifery practitioner implemented the strategies for the mother with pregnancy loss. This implementation principle required guidance and support for those assigned to the activities and this was provided by the advanced midwifery practitioner. Should any problem arise, remedial action should be applied to correct the situation. Implementation of the plan was discussed separately.

Health worker to improve support for mothers with prenatal loss

This was based on the findings in phase II, that the midwives and doctors lacked knowledge about the physical, emotional and social impact on individuals and families after prenatal loss. Bereavement was also a source of discomfort which frequently spills over into care-giving, rendering it inadequate and often detrimental (Lang et al, 2005). The study by Gardner (1999) emphasized common needs of caregivers for increased knowledge, mentored experience and personal support to confidently provide sensitive care to families. Furthermore, although the needs of bereaved parents have been explored by researchers, there has been little mention of the needs and feelings of prenatal nurses and midwives who care for them. Gardner's study demonstrated that many nurses felt anxiety and lacked both education and experience. They indicated a need for education regarding the grieving process of parents who experience prenatal loss; specific interventions for bereavement care; and supporting and consoling communication techniques. Some nurses did not know how to respond to parents, whereas others did not know how to express their own grief. Other needs indicated by the participants included education in bereavement counseling, experience under guidance of a senior staff person, emotional support and 'an arena for open discussion and debriefing'.

The following strategies were implemented:

- Stress management
- Improvement of knowledge and skills of the health worker.

NB: Both the stress management and training in counseling skills should run concurrently in order to succeed in the programme and to achieve the goal.

Stress management

This strategy was necessary because it emerged from the interviews that the health workers are unable to give adequate support to mothers with pregnancy loss, because they worked under a lot of stress due to an increased workload and staff shortages. They have therefore, lost motivation in doing tasks, for example, supporting mothers with pregnancy loss: One participant said: *'I get tired, I get very emotional, I start crying. Then how can I comfort another person?'* According to Fraser et al (2006) the role of the midwife manager in creating a suitably supportive environment for staff working in stressful situations should not be under-estimated. The stress management followed the following steps:

- Keeping a reflective journal
- Forming a support group.

Reflective journal keeping

Before forming the support group, the health workers (midwives and doctors) were encouraged to keep a reflective journal during off-duty time or during breaks, in which they would document all the activities in the working environment. Keeping this journal would develop the ability of the health workers to be their own internal supervisors, and would extend and maintain awareness of self and

others. They were encouraged to record all feelings and memories as these unfold, and to emphasize whatever it was important to remember. This journal should be updated frequently, whenever there is new information. The health worker could refer to this journal when there is a need to explain the specifics of incidences, for example, during the mutual support. This can sometimes be therapeutic because it allows the health worker to create a private outlet for negative thoughts.

Formation of a support group

In order to succeed in facilitating the care of mothers with pregnancy loss, the formation of a support group for health workers was necessary. The group was designed to help health workers to cope with the environmental stresses and to sustain and enhance their coping abilities. This enabled psychological closeness, encouraged by the knowledge that members share similar concerns that are often not well understood by others. It also offered understanding, information and mutual aid. And according to Gardner (2005) spiritual, psychological, and emotional support to midwives and nurses is needed for them to be able to support bereaved parents and their families. Feelings about death and dying to each culture need to be explored. Willing colleagues with whom to express feelings, to discuss dilemmas, and to debrief after ministering to the bereavement are essential to them.

Improvement of knowledge and skills of the health worker

This was achieved by organizing a week-long workshop in order to improve their knowledge and skills. The course can run according to the institution's needs as it was highlighted in the study that midwives and doctors lacked knowledge and skills to care for mothers with prenatal loss. Gardner (1999) emphasized common needs of caregivers for increased knowledge, mentored experience, and personal support to confidently provide sensitive care to families.

As stated by Andrews (1997), it must first be established whether the need did in fact arise from a lack of training, so that the programme may be relevant to the existing needs. In this study it was established that caregivers are working under stressful conditions and that they lack the skills and knowledge to care for mothers with pregnancy loss: One participant said: *'I deliver a mother and I don't really know where to start or what to say. Because of fear that I may say wrong things, I just avoid the mother as much as I can.'*

Improving support to the mothers with pregnancy loss

Multi-disciplinary approach/teamwork

Teamwork is the collaboration of various professionals in a team on an equal basis and to enhance mutual collaboration. Teamwork involves a group of human beings who acknowledge membership and the clear value and necessity of shared experience and co-operation. A team comprises a number of skills and characteristics (Collins, 1984). According to Gardner (1999) multidisciplinary conferences targeting causes of prenatal death, effective interventions and care of the bereaved should be regularly scheduled. Collaboration strategies should be addressed at these meetings for purposes of improving the quality of care to the bereaved and providing support to the professionals. Prenatal nurses and midwives should be included in physician's discussions with bereaved parents and should participate in decision making regarding their care.

The Canadian Health Services Research foundation on teamwork (2006) says that an effective way of improving the quality of care and patient safety is by reducing staff shortages and stress and burnout among professionals.

Organizational changes of wards

It is important for these women to be admitted in separate antenatal clinics, wards, gynecological wards and side-wards of the labor wards. One doctor commented:

'I think it is better that mothers who have lost their babies should be transferred to the gynecological ward, because when you hear babies crying, and see mother's breastfeeding their babies, you wish you could be doing the same. It is so frustrating.'

Goals of organizational changes

Caregivers will not have any other responsibility but to look after these mothers, whereas, if they are to look after other mothers too they will have less focused time. As indicated in this study, given a choice, caregivers will give time to mothers with live babies n Caregivers will have ample time to support mothers with prenatal loss without rushing to care for other mothers n Mothers will be given the necessary privacy, given time to make informed decisions and have a better chance to say goodbye without any distractions. There will be limited noises of non-stress test machines and babies crying. Open time for visitation, that is, there should not be a restriction of visitors.

This is confirmed by Gardner (1999) in a study which showed that bereaved parents acknowledged that unrestricted visiting hours for families, provision

of privacy and opportunities for fathers to remain overnight in the hospital with mothers are helpful strategies.

'Sometime after the delivery of a stillborn baby, you would like to have a loved one around you all the time, to comfort you.'

Robinson and Thomson (1999) added that if the woman remains in the postpartum area, subtle signs such as a teddy bear or flower outside the door can alert the staff that the family has experienced a loss, preventing inadvertent questions regarding the status or location of the infant.

Support system

The in-patient support system

This is the care the mother will receive while in hospital. It is the duty of the midwife who is attending to the patient to co-ordinate the in-patient support system. According to Mander (2003) the midwife is in a privileged position of being able to be with the woman when she first faces her loss. They should initiate the communication network by informing the inter-disciplinary team of the presence of the mother with a pregnancy loss. The midwife is supposed to insert the checklist into the mother's records/notes. The checklist will give details of items and procedures appropriate to pregnancy loss, and it remains with the woman until discharge. According to Lunqvist and colleagues (2002) using the checklist should be flexible, so that the nurses are able to individualize the treatment according to the wishes of the family. The woman is given a decision-plan form, which explains the decisions that must be made during the first few days after delivery regarding events that will occur. Sometime during the first hour of delivery the issue of performing an autopsy is carefully and compassionately introduced. The importance of the results is also discussed, because these procedures and decisions will be discussed later (Woods and Esposito, 1987).

The in-patient support will help bereaved parents to validate a healthy grieving process, allowing families the opportunity to view the dead infant and hold the infant if desired contributing to validation of the loss. Pictures or mementos, including footprints, handprints, locks of hair, and receiving blankets, confirm that the pregnancy did exist. Additionally, the importance of taking photographs cannot be stressed enough. Although families initially may state that they do not wish photographs, they may find great relief in the fact that photos were held in the file and could be received at a later date.

The out-patient support system

Mereinstein and Gardner (1993) mention that grieving parents need follow-up care and contact with professionals. Follow-up meetings function as a catharsis for parents, as well as an opportunity for assessment, counseling, and possibly referral. Primary care providers (physicians, nurses and social workers) from the prenatal setting may provide follow-up. For the family, relating to care providers with whom a relationship has already been established may be easier than establishing a new relationship with a stranger. In the first few out-patient counseling sessions, the directive and instructional approach to patient counseling serves several purposes.

In Gardner (1999) midwives said that they visited families at home ten days following their discharge, and the midwife related that bereaved parents talk more freely and express their feelings more openly in their own environment. Parents may contact midwives by telephone, not only at the hospital but also at home. One midwife said:

'we routinely call the parents a few weeks after their home visits to let them know we are still thinking of them and offer continuing care if they wish.'

Enhancing trustworthiness

Trustworthiness refers to the extent to which a research study is worth paying attention to and the extent to which others are convinced that the findings are to be trusted (Babbie and Mouton; 2001). The criteria established by Babbie and Mouton (2001), Leininger (1990) and Lincoln and Guba (1985) served as guidelines for the researcher. To enhance credibility data triangulation by interviewing key and general informants was applied. Knowledge as a health professional and clinical experience as well as the literature that was consulted enabled the researcher to satisfy the criterion of being knowledgeable about the phenomenon under investigation. The researcher bracketed current knowledge and preconceived ideas and especially personal views about the existing problems in the clinical area.

Semi-structured interviews were conducted until data saturation occurred, namely until the collected data were repeated and confirmation of previously collected data took place (Streubert and Carpenter, 1999). To enhance conformability an audit trail was established by attaching the coding system to a research report by filling the raw data and the researcher's interpretations were scrutinized by research supervisors who acted as independent coders. The categories identified by the researcher were contrasted with those identified by the supervisors. No major discrepancies were identified between these persons' analysis of the data. For transferability to be judged in-depth discussions of the data obtained were recorded and data analysis and interpretation of the research findings was included in a research report.

Evaluation of the guidelines

The guidelines were presented on two occasions. At a research forum of a university it was presented to academics and researchers as well as masters and doctoral students. They made in-puts regarding the scientific aspects of the framework. It was also presented at one of the colleges in Gauteng province. The people invited were doctors, midwives and tutors who are involved in the support of mothers with pregnancy loss. They were given the opportunity to discuss the guidelines in depth. These were well accepted and the recommendations are listed below:

- It should be implemented in the clinics
- The researcher should have invited the policy makers of the hospital also because they would see the need for the implementation of the support programme, and the final say would lie with them
- This should be included in the curriculum of both midwives and doctors in training to bridge a gap.

Recommendations

The recommendations derived from this study are classified into those related to practice, education and research.

Nursing practice

The guidelines should be presented to the managers and policymakers of the hospital. Permission should be sought to implement these from the managers The effects of these guidelines on the health workers as well as the mothers should be evaluated after implementation.

According to Hughes and colleagues (2002) staff is also shocked and upset when there is a stillbirth. Inexperienced staff might feel at a loss to know what to say or do, and perhaps the protocol gives them reassurance that there is a 'right' way to manage the situation. Therefore, if the prenatal bereavement programmes are developed, caution should be taken against 'institutionalization of bereavement' and reiterates that interventions be sensitive to the individual differences of grieving families (Backer and Nackerud 1999).

Education

The guidelines should be included in the curriculum of the midwives and doctors. It should be taught when they are in training so as to equip them with the knowledge and so that when they finish they already have the necessary skills. As students, both midwives and doctors could be used as implementers and evaluators of this support programme during their practical training. This is reiterated by Gardner (1999) that parents should provide feedback regarding nursing interventions. Their suggestions for improving nursing care should be communicated to the Nursing Department and incorporated into the curriculum. The study goes further to say that schools of midwifery and nursing must include culturally sensitive care practices for bereaved families. By giving students this basic knowledge, by having them consider their own feelings about death, and by rehearsing supportive communication techniques, these students will be better prepared to support the bereaved.

Research

The effectiveness of the guidelines should be evaluated in different contexts. Standards and instruments should be developed to measure the quality and effectiveness of the programme. Further research should be conducted in different institutions which involve other racial groups.

Limitations

The research was conducted in a single institution in Gauteng province. It did not include other race groups as this hospital admits black people only. Therefore, the research findings are contextualized within the public hospital setting where the research fieldwork was conducted; hence the results of the qualitative research are not value free. Another limitation is that the researcher did not always gain the co-operation of the staff in the clinical area. They failed to contact her when they admitted mothers with prenatal loss and, when the researcher needed to interview the health workers; they would sometimes postpone the encounter.

Conclusion

Through this research guidelines were developed to assist the midwives and doctors to support mothers with pregnancy loss were developed. According to Lundqvist and colleagues (2002) the development of prenatal bereavement programme will help staff to inform, counsel and support the parents. The aim is to facilitate the parents' grief process when losing a baby. It is clear from the findings of this study that the doctors and midwives need to work together and be committed to supporting the mothers with pregnancy loss. The tears that fell during the interviews in this study send a clear message to the medical fraternity that the mothers with prenatal loss are in great need of support.

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