

PERINATAL LOSS

Perinatal loss may occur anytime during gestation or the neonatal period. Usually when pregnancy culminates in the death of a fetus or neonate, the loss is both unexpected and devastating for the client/couple. The loss of a child that is wanted can be as traumatic (or even more traumatic) as the loss of a close adult family member or friend. This plan of care focuses on the emotional needs of the postpartal client who must cope with the death of a child.

(To be used in conjunction with routine postpartal plans of care).

CLIENT ASSESSMENT DATA BASE

Circulation

History of essential hypertension, vascular disease

Ego Integrity

Emotionally labile; anxiety, fear, shock, disbelief, depression

Elimination

Chronic nephritis

Food/Fluid

Poor maternal nutritional status

Safety

Exposure to toxic/teratogenic agents

History of traumatic event(s)

Presence of pelvic inflammatory disease, sexually transmitted diseases (STDs), or exposure to contagious diseases, such as rubella, cytomegalovirus, active herpes

Premature rupture of membranes

Abnormalities of placenta/cord noted at delivery

ABO incompatibility

Sexuality

Bicornate or septate uterus, uterine fibroid tumors (leiomyoma), or other abnormalities of the maternal reproductive organs

Occurrence of traumatic delivery; intrapartal complications

Teaching/Learning

May report medication, drug (including alcohol) use or abuse

Family history of genetic conditions

DIAGNOSTIC STUDIES

(Refer to CP: Genetic Counseling.)

NURSING PRIORITIES

1. Facilitate the grieving process.
2. Provide information regarding events surrounding the loss and future implications.

DISCHARGE GOALS

1. Supports identified and in place
2. Plans made for disposition of infant's body
3. Demonstrated progress in dealing with grief at own pace

NURSING DIAGNOSIS:

Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/COUPLE WILL:

GRIEVING [expected]

Death of fetus/infant

Verbal expression of distress, anger, loss, guilt; crying; alteration in eating habits or sleep pattern

Identify and express feelings (e.g., sadness, guilt, fear) freely.

Acknowledge impact/effect of the grieving process (e.g., physical problems of eating, sleeping) and seek appropriate help.

Participate in self-care activities of daily living (ADLs), as able.

Look toward/plan for future, one day at a time.

ACTIONS/INTERVENTIONS

Independent

Code patient's chart, room door, and/or head of bed, as indicated.

Provide a private room if client desires it, with frequent contact by care providers. Encourage unlimited visiting by family and friends.

Support free flow of emotional expression. Only limit behavior that is dangerous to well-being of client/couple (e.g., pulling out IV, using fists to pound on abdomen).

Include partner in planning care. Provide opportunity for partner to be seen individually. Encourage discussion of concerns.

RATIONALE

Alerts hospital staff and volunteers so they are aware of patient's loss.

A place where family and friends can talk or cry without restriction promotes ventilation of feelings and family sharing. Note: Client may prefer carefully screened roommate(s), who can provide contact and comfort when family and friends are not available.

Expression of grief is impacted by cultural/religious beliefs and expectations running the gamut from stoic silence to screaming and pounding one's chest/throwing objects, etc. While expression of loss is cathartic, extended stoicism may impede mourning process.

Participation in planning and decision making acknowledges that partner has also lost a child and may need time to express feelings of loss and receive support without having to be supportive of client and others.

Assess client's/couple's knowledge and interpretation of events surrounding the death of the fetus/infant. Provide information and correct misconceptions based on couple's readiness and ability to listen effectively.

Determine significance of the loss for both members of the couple. Note how strongly couple desired this pregnancy.

Identify stage of grief being expressed, e.g., denial, anger, bargaining, depression, acceptance. Use therapeutic communication skills (e.g., Active-listening, acknowledgment), respecting client's desire/request not to talk.

Discuss the individual nature of movement through the stages of grief; tell client/couple that delays in the grief process or relapses of grief are normal.

Note communication patterns between members of the couple and support systems.

Encourage family's expression of feelings and listen (remaining silent or commenting as appropriate). Note body language. Promote relaxed atmosphere.

Acknowledge what has happened as often as necessary, reinforcing the reality of the situation and encouraging discussion by the client.

Often, after the death of a child, parents respond with shock, denial, or disbelief. These emotional reactions may hinder the couple's ability to process information and interpret the significance of events. Concrete thinking patterns (literal interpretation) may be the only available means of coping with information at this time.

The significance of the loss is a factor (e.g., whether pregnancy was planned, whether couple has lost other pregnancies, length of time associated with trying to conceive) in the extent and duration of the grief response. In addition, parents may feel the loss throughout their lives, mourning for the child they will never know or watch grow up.

When a child dies in utero, is stillborn, or dies after birth, grief is felt regardless of whether the child was wanted or unwanted. If the work of grieving is not completed, grief may become dysfunctional, resulting in behaviors that are detrimental to personal safety and to the future of the family and marriage/relationship.

The process of grieving is not usually a fluid progression through the stages to resolution; it is rather a fluctuation between stages and possibly involves skipping of stages. Understanding that grieving is individual helps the couple let each other grieve at his or her own pace. Note: There is no set time limitations for resolution of grief and it is not unusual for the family to be actively dealing with the loss 1–2 yr later.

In many cases, parents show anger and blame toward one another. Anger may stem from fear of losing another child or threat to self-esteem.

Verbal and nonverbal cues provide information about family's degree of sadness, guilt, and fear. Grieving families need repeated opportunities to verbalize their experience. Time is needed to develop a therapeutic milieu. Active-listening conveys caring, which communicates an awareness of the unique meaning of the loss to the client.

Many families have no previous experience of coping with the death of a young person and have few role models to whom they can refer. The nurse can act as an educator and facilitator regarding ways to act and talk about the event and can clarify misconceptions.

Take pictures of the child wrapped in newborn attire. Encourage couple to see or hold the child, if appropriate. Offer the couple footprints, hospital bracelets, or lock of hair, if desired.

Note client's activity level, sleep pattern, appetite, and personal hygiene.

Provide physical care (e.g., bath, back rub, nourishment) as needed. Encourage client to participate at level of ability.

Discuss anticipated physical and emotional responses to loss. Evaluate coping skills. Note religious beliefs and ethnic background.

Review role changes and plans to deal with loss. Note presence of siblings.

Discuss ways for parents to talk with siblings. Stress importance of words that are used, such as when the word "sleep" is substituted for "death." Encourage parents to give simple, honest explanations, using correct words, at the level of the child's understanding.

Assess severity of depression.

Review the client's/couple's verbal cues regularly. Note signs of developing or increasing somatic complaints, preoccupation with the death, loss of normal behavior patterns, overactivity with no apparent sense of loss, excessive hostility, or agitated depression.

Collaborative

Refer to, or contact, clergy, according to family's wishes.

Pictures and touching or holding infant can be helpful and may initiate acceptance of the reality of the loss. Note: Couple may not be ready to cope with the loss. Remembrances of the infant, if not taken by the parents, should be filed with the chart, so that they are available if couple requests them at a later time.

These areas may be neglected because of the process of grieving and associated depression. Sleep patterns may be disrupted, leading to fatigue and further inability to cope with distress. Client may need assistance in meeting physical needs and may need assurance that it is acceptable to continue with usual activities.

Demonstrates caring and nurturing and helps client conserve energy needed to meet the demands of the grieving process. Involvement in self-care maintains self-esteem and sense of competence.

Helps couple recognize normalcy of their initial and subsequent responses. Grieving is individual, and the extent and nature of the response is influenced by personality traits, past coping skills, religious beliefs, and ethnic background.

Most families anticipate a healthy pregnancy and positive outcome and are not prepared to focus on funeral arrangements, what to do with the nursery, how to carry on their lives, and how to plan for the care of the other children.

Provides parents with ideas for handling difficult new experience. Siblings' sleeping patterns may be disturbed by their belief that they may also die. Siblings may feel guilt or responsibility for the death, especially if they had negative thoughts about the pregnancy or infant.

Client/couple may isolate themselves and have difficulty making decisions.

May indicate change in client's/couple's manner of coping with the situation. Guilt, failure, and depression may be more pronounced in couples who have had previous child loss(es). Other signs may suggest dysfunctional grieving.

The family may want to speak to a minister or spiritual advisor to provide baptism, last rites, cultural rituals, and/or counseling. Note: Baptism is not acceptable in some religions (e.g., Jehovah's Witness, Seventh Day Adventist).

Assist with making requests and obtaining signatures for performance of autopsy if appropriate. Review benefits and limitations of autopsy.

Provide information about disposition of infant's body. Contact mortician of family's choice if assistance is required.

Refer to, or contact, social services, if necessary.

Schedule follow-up meetings or phone calls, as appropriate. Refer to community resources/support groups (e.g., visiting nurse services, Compassionate Friends, AMEND, SHARE).

Refer for counseling or psychiatric therapy, if necessary.

Families may want or need explanation of cause of death, which may not be possible.

Bodies of children, like those of adults, must be removed from hospitals to mortuary facilities or other disposition, usually within 24 hr of death. While burial may be delayed in most instances, Jewish tradition requires burial within 24 hr, which may further complicate client's grieving process if she is not able to attend ceremony.

Family may need assistance in planning for cost of funeral and other necessities.

Provides client/couple with opportunity for discussion and asking questions. Assists client/couple at critical moments in the grief process, providing role models and opportunity to discuss loss with others who share similar experience.

Severe grief response may be noted in older women and those with longer-term pregnancies. In addition, carrying the fetus for 1 or more days after death increases risk. In cases of pathological grief, ongoing counseling may be necessary to help individual(s) identify possible causes of the abnormal reaction and to achieve resolution of the grieving process. Note: Risk of major depression episode is highest during the 1st month following the loss, whereas women without other children or who have had a prior depressive episode remain at increased risk for 6 months.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—FAMILY WILL:**

FAMILY PROCESSES/ROLE PERFORMANCE, risk for altered

Situational crisis (death of child)

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Express feelings freely and appropriately.

Demonstrate individual involvement in problem-solving process directed at resolution of crisis.

Verbalize understanding of role expectations/ obligations.

Identify needs and resources to nurture roles/family ties.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Evaluate current family situation and psychosocial status (e.g., other children, extended family, support systems).

Review family's strengths, resources, and past coping skills.

Encourage discussion of feelings and listen for verbal cues indicating feelings of failure, guilt, or anger. Discuss normalcy of feelings.

Discuss situation in terms of activities that need to be completed or continued and the available resources.

Identify expected role changes required by the loss.

Provide information and assist parent(s) in dealing with the situation, balancing self-care, grief needs, and parenting responsibilities.

Offer client simple choices of activities, with the opportunity to do more as she progresses.

Collaborative

Refer to resources such as social services, visiting nurse services, and other agencies.

Refer to parent support groups (e.g., Compassionate Friends, SHARE).

Family members may provide support for one another. However, disbelief, anger, and denial may temporarily impair parenting skills, and other children may be ignored or treated differently from the way they had been treated before the death of the infant.

Family members may be depressed, may feel totally inadequate, and may need to review what has happened and what their purpose in life may be.

Verbalization of feelings may trigger recognition of their causes and can be used to verify the acceptability of these feelings. Parents may be afraid to describe negative feelings that they consider abnormal. Realization that feelings of grief, guilt, and anger are normal may help alleviate the parents' sense of failure.

In many cases, grief causes immobilization, resulting in dysfunctional parental patterns to the point that normal household routines are disrupted and outside assistance is required.

Anticipated changes include period of disorientation or breakdown in normal patterns of conduct, followed by a period of reorganization, in which energy is appropriately invested in new people and activities.

Death of a child requires unanticipated changes in parental roles. With death of a first child, the only parental function that occurs is grief. If there are other children, however, parents may express concern about their parenting abilities. Feelings of failure or guilt may lead to a sense of ultimate inadequacy.

The client needs to receive the message that she is seen as a functional, capable person, even though she may not feel competent.

May be necessary to assist family members or to replace them when they are not available to help (because of distance and/or their own lack of coping skills). Fosters growth and individuation of family members.

Reviewing the situation with others who have gone through the same process can reaffirm normalcy of parents' feelings and responses. Note: Referral is best made when the client/couple is experiencing depression and shock. It is more difficult to refer the client/couple during the stages of denial and anger.

Refer for psychiatric counseling or psychotherapy, if indicated.

Administer medications judiciously, as needed (e.g., sedatives, antianxiety agents/antidepressants).

Additional support in coping with grief may be needed. Psychotherapy may be helpful in cases of pathological grief or overprotectiveness, which can negatively affect normal parenting and integration of loss into usual activities.

May help client obtain sleep/rest (e.g., following difficult or exhausting delivery or cesarean birth).
Note: Inappropriate use of medications can cloud emotional responses and inhibit the grieving process.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION

CRITERIA—CLIENT/COUPLE WILL:

SELF ESTEEM, situational low

Perceived failure at a life event

Negative self-appraisal in response to life event in a person with a previous positive self-evaluation, verbalization of negative feelings about the self (helplessness, uselessness), difficulty making decisions

Identify strengths and resources available.

Express positive self-appraisal.

Demonstrate adaptation to death of infant and integration of loss into daily life by planning for the future.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Determine couple's self-perceptions as individuals and parents. Evaluate family's response to loss, noting blame placed by family members.

Discuss with parent(s) what has occurred and ascertain how they perceive the death.

Discuss destructive behaviors, differentiating the responses of others from self-elicited responses (e.g., expressions of blame and/or guilt).

Giving birth provides opportunities for giving love, being loved, building self-esteem, feeling proud and accomplished, establishing a reason for living, and creating a bridge to the future. Loss of the pregnancy and newborn is, therefore, frequently associated with feelings of inadequacy, powerlessness, and inferiority, directly affecting sense of self and possibly shattering one's self-esteem as a parent. Expression of anger or blame by other family members may further reduce self-esteem.
Note: Sense of loss/failure may be exacerbated in cases of repeated miscarriages or serial fetal/neonatal deaths.

Anger among family members may be transferred to client/couple, resulting in a distortion of actual events.

Destructive behaviors may be apparent during the phases of anger, isolation, and depression. Denial may be used as protection against loss of self-esteem. Guilt may be verbalized, especially if the loss is related to a genetic problem, uterine trauma (e.g., car accident or fall), or teratogens from environmental exposure or drug ingestion.

Provide opportunity for verbalization, venting of emotions, and crying.

Discuss parenting needs of other children, as appropriate.

Provide positive reinforcement for expressing needs and identifying concerns.

Collaborative

Provide referrals for counseling and assist with coordination of appointments (e.g., with social services or support groups).

Sharing of loss provides opportunity for needed acceptance, helps parents sort through feelings, and validates parents' normal feelings of powerlessness and inadequacy.

Continuing to care and to feel needed assists in preserving client's/couple's identity as worthwhile parent(s).

Aids in coping with sadness of situation. Helps parents accept themselves as worthy human beings.

Client's/couple's ability to coordinate and perform tasks may be compromised. Referrals help provide support and assistance, which can facilitate integration of loss into daily life and enhance self-esteem.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION

CRITERIA—CLIENT/COUPLE WILL:

SPIRITUAL DISTRESS (distress of the human spirit), risk for

Need to adhere to personal religious beliefs/practices; blame for loss directed at self or God

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Discuss beliefs/values about spiritual issues.

Verbalize acceptance of situation and hope for the future.

Demonstrate ability to help self and/or participate in usual activities.

ACTIONS/INTERVENTIONS

Independent

Discuss the loss with client/couple. (Refer to ND: Knowledge deficit [Learning Need]).

Identify supportive relationships and resources to use after discharge (e.g., extended family, friends, or religious affiliations).

RATIONALE

Grieving and trying to make sense out of the loss and to find meaning in life without the baby may cause the couple to question their religious beliefs and to feel cheated or angry. Discussion of objective findings can help the client/couple begin to cope appropriately with feelings of distress.

Use of a support system is a constructive means of coping with grief and maintaining perspective.

Encourage discussion of perceptions of unfairness. Identify such perceptions as part of grief process. Maintain a nonjudgmental attitude while providing opportunity for client/couple to express anger.

Families suffering perinatal loss often question their religious beliefs and are concerned about the purpose of life and death. Anger related to powerlessness may result in placing blame on oneself or someone else, or at God for “selecting them to suffer.”

Collaborative

Refer to hospital chaplain, rabbi, or appropriate spiritual advisor. Work with mortician, as appropriate, in assisting family with plans for funeral.

Specialists in spiritual beliefs and ritual may be needed to help in making decisions related to burial and loss. Symbolism and ritual can provide comfort and connect family members with their spiritual beliefs.

NURSING DIAGNOSIS:

KNOWLEDGE deficit [LEARNING NEED], regarding perinatal loss, future expectations

May Be Related To:

Lack of exposure to, or unfamiliarity with, information resources, misinterpretation of information

Possibly Evidenced By:

Request for information, statement of misconception

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Differentiate between causes of death that are controllable and those that are uncontrollable.

Verbalize understanding of reasons for loss, when known.

Discuss possible short- and long-term effects of the loss.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess family’s readiness and ability to understand and retain information.

Emotional responses may interfere with the ability to hear and process information. The stage of denial is not the best time for the individual to attempt to process information, and repetition of information may be needed because of the individual’s uncertainty about, and lack of control of, the situation. Simple reinforcement of reality may be all that family members are receptive to at the moment.

Provide information about possible short- and long-term physical and emotional effects of grief, including somatic symptoms, sleeplessness, nightmares, dreams of the infant or the pregnancy, emptiness, fatigue, altered sexual response, and loss of appetite.

Review sequence of events and diagnostic tests performed, using pictures if available and appropriate.

Identify family's priorities when providing information.

Allow client to introduce the subject of another pregnancy.

Identify client's/couple's perceptions of events, and correct misunderstandings, as indicated.

Prepare parents for reactions of friends and family; role-play responses.

Refer to chaplain and community support groups. (Refer to ND: Spiritual Distress, risk for.)

Review information provided by referral agencies/groups.

Discuss appropriateness of genetic counseling as indicated.

In many cases, parents do not know why their child died and may have a fear of future pregnancies. Causes of intrauterine death, still-birth, or perinatal death are sometimes uncertain even after autopsy, and families may feel guilty about the cause of death. Providing information about these factors can be helpful in resolving the grief of these individuals. Helps prepare couple for normal changes and difficulties associated with usual activities of daily living, and helps couple recognize extent of loss.

During the severe stress that follows the loss, the client/couple understands and retains information more easily if it is presented in a concrete manner. Symbols such as footprints or pictures of the infant may be important.

Families have different needs for information, depending on the stage of family development and on whether death was intrauterine or caused by external factors or genetic problems.

Individuals determine their own readiness to think about and discuss this possibility. The usual recommendation is to avoid considering pregnancy until grief has been resolved, or until at least 6 mo after the loss.

Inaccurate perceptions need to be assessed on a continual basis and valid information reiterated.

Family members and friends often do not appreciate the intensity of the parents' grief. Role playing can prepare parents for varied responses from friends and relatives, who may avoid talking about the loss, mistakenly believing that avoiding the topic is therapeutic/less painful for parent(s).

In many cases, the parents do not trust information until they have heard it from multiple sources.

Support groups provide information and assistance from people who have experienced similar losses and provide reassurance of normalcy of physical and emotional responses.

Genetic counseling may be suggested if the parents fear reoccurrence of the problem, even if the problem is not thought to be genetic. The terms "congenital," "teratogenic," and "trauma" should be defined and differentiated so that parents can comprehend risk factors.