

A Collaborative Framework for Managing Pregnancy Loss in the Emergency Department

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ABSTRACT

The purpose of this article is to examine how nurses can improve comprehensive care for women who suffer an early pregnancy loss in the emergency department and highlight the integral role of obstetric and emergency department nurses within a new holistic framework of collaborative care. These nurses are integral in the proposed collaborative "fetal loss framework," which provides an innovative approach for holistic care for this population.

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Ms. Terri Jones was 18 years old and 7 weeks pregnant when she experienced vaginal bleeding accompanied by such severe abdominal cramping that the pain woke her out of a sound sleep. After she had soaked through one sanitary napkin, she began to panic. She lived alone, had no contact with the father of her baby, and did not want to call her family. Terri had not contacted an obstetrician or nurse midwife for early prenatal care due to fear and lack of knowledge about resources available to her. With nowhere else to turn, Terri drove herself to the closest emergency department (ED). As she entered the registration/waiting area, crowded with people sitting in all available seats, in wheelchairs, on the floor and in the hallway, she was approached by a security officer who told her to sign in. When the triage nurse finally called her name, she was directed to a tiny room where her focused history, vital signs, rapid hemoglobin test, and urine pregnancy test were completed. Her vital signs and hemoglobin were normal. Terri was told that the ED was crowded, was "boarding" many admitted patients and was on "ambulance diversion." She was advised not to eat or drink anything, to take a seat, and that she would be brought to an exam room as soon as one became available.

After waiting 4 hours, Terri began to feel nauseated and more uncomfortable. She went to the bathroom to urinate and noticed the bowl was filled with blood, clots, and one very large clot. She flushed it all in a panic and returned to triage where the nurse sat her down, assessed her skin and vital signs (which were normal), and placed her on a stretcher in the hallway. Tearful and frightened, Terri waited alone, curled in a fetal position, lying in a cold ED hallway while patients, visitors, paramedics, and staff passed quickly by, averting their eyes.

Terri is not alone. For many women, the visit to the ED with pelvic pain or bleeding may be the first and only clinical encounter of the pregnancy. According to the National Center for Health Statistics (Pitts, Niska, Xu, & Burt, 2008), out of the 119.2 million annual visits to hospital EDs, approximately 1.4 million (1.2%) of those were visits for complications of pregnancy and childbirth. An estimated 175,000 women seek care for pregnancy loss every year in the ED (Wittels, Pelletier, Brown, & Camargo, 2008).

Since the focus of ED care is to diagnose quickly and intervene on disorders with the "greatest potential for morbidity and mortality" (American College of Emergency Physicians [ACEP], 2003, p. 123), preservation of life takes center stage. Because the

priority of care in the ED is focused on providing life-saving interventions, stabilization of critically ill and injured patients, and treatment of episodic illness (Emergency Nurses Association Position Statement, 2000), it may be a challenge for ED nurses to provide the kind of holistic care needed by women experiencing a pregnancy loss. The purpose of this article is to examine how nurses can improve comprehensive care for women who suffer an early pregnancy loss in the ED and highlight the integral role of obstetric and ED nurses within a new holistic framework of collaborative care.

Pregnancy Loss

In an effort to design a framework for holistic care for the ED patient facing a pregnancy loss, a review of the literature was conducted on pregnancy loss focusing on the perceptions and experiences of women, the standard of care for ED treatment, and grief reactions following pregnancy loss. The literature search was performed using MEDLINE, CINAHL, and WEB OF KNOWLEDGE. The following key words were searched alone or in combination: pregnancy loss, abortion, miscarriage, vaginal bleeding, emergency department, loss and grief.

Definition of Pregnancy Loss

Pregnancy loss, also called miscarriage or spontaneous abortion (SAB), refers to the loss of a pregnancy without outside intervention before 20 weeks gestation (Callister, 2006; Griebel, Halvorsen, Golemon, & Day, 2005; Price, 2008a). The term "pregnancy loss" has been adopted because of the religious and emotional feelings associated with commonly used medical terminology such as abortion and miscarriage and because "pregnancy loss" acknowledges the emotional concerns of losing a child (Griebel et al.; Callister). A diagnosis of abortion may be further categorized into threatened abortion, inevitable abortion, incomplete abortion, missed abortion, septic abortion, complete abortion, and recurrent SAB (Griebel et al.). The term miscarriage can also be further categorized into threatened miscarriage, inevitable miscarriage, complete miscarriage, incomplete miscarriage, septic miscarriage, and delayed miscarriage (Coppola & Coppola, 2003).

Epidemiology of Pregnancy Loss

Approximately 210 million women across the world become pregnant each year, and of these pregnancies approximately 15% to 20% will end in miscarriage or stillbirth (Curtis, 2007; Gabbe, Niebyl, & Simpson, 2002; Griebel et al., 2005). The

latest figures indicate that the fetal mortality rate in the United States is 6.22 fetal deaths per 1,000 births (MacDorman & Kirmeyer, 2009). Because many women suffer pregnancy loss and never seek medical care, the number of women experiencing a pregnancy loss may be grossly underreported. In one longitudinal study of childbearing women, approximately 25% of women reported one or more pregnancy losses (Price, 2008a).

Risk Factors

Some risk factors for early pregnancy loss can be modified in an effort to prevent repeated spontaneous losses. Approximately 50% of all miscarriages are caused by chromosomal abnormalities involving the fetus (Coppola & Coppola, 2003). Environmental factors have been implicated as a possible cause of fetal loss, especially related to exposure to toxins and occupational hazards (Brown, 2008; Weck, Paulose, & Flaws, 2008). Other risk factors highly associated with pregnancy loss include age, previous fetal loss, and over-the-counter and illegal drug and alcohol use (Coppola & Coppola; Goddijn & Leschot, 2000; Tulandi & Al-Fozan, 2008). The risk of a spontaneous loss is 20% after having one such loss, 28% after having two, and 43% after having three or more (Tulandi & Al-Fozan). The following have also been identified as risk factors for pregnancy loss: advanced maternal age; previous SAB; multiple previous elective abortions; smoking; drug/alcohol use; prolonged time between ovulation on implantation; prolonged time to achieve pregnancy; low folate levels; BMI less than 18.5 or greater than 25; celiac disease; environmental toxins; maternal infections; polycystic ovaries; intrauterine device; and uterine abnormalities (Coppola & Coppola; Goddijn & Leschot; Griebel et al., 2005; Tulandi & Al-Fozan).

Maternal Death From Pregnancy Loss

Every patient of childbearing age with suspected pregnancy loss should be evaluated for any life-threatening complications of pregnancy. The goal of the ED nurse is to act swiftly to make sure the patient is stabilized. In a study by Hawkins (2003), 59% of maternal mortality in the United States was found to be preventable if diagnosed and treated in an expedient manner. The four most common causes of preventable maternal deaths are hemorrhage, pregnancy-induced hypertension, infection, and ectopic pregnancy (Hawkins). The ED nurse is focused on providing life-saving measures by quickly recognizing and treating these complications of pregnancy. Once the patient is stable, emotional and spiritual needs should be addressed.

Lack of access to primary care is a major reason for emergency department utilization as the woman is in crisis and has no practitioner.

Emergency Department Challenges

Women experiencing a loss go to the ED for care for different reasons. For some women, the fear and anxiety associated with symptoms, typically bleeding and cramping, are so overwhelming the ED seems the appropriate care location. Many lack access to care.

Access to Care

In a recent survey of seven industrialized countries regarding access to primary care and care coordination between multiple providers, U.S. adults were least likely to report having a regular doctor or adequate coordination of health information between different sites and providers (Schoen et al., 2007). There have been many reasons cited for this lack of access to care including lack of insurance or inadequate insurance, education, cultural, linguistic, logistical, psychosocial, and environmental and institutional factors (Richardson & Hwang, 2001). This lack of access to primary care is a major reason for ED utilization as these women had no practitioner initially diagnosing or managing the pregnancy, no practitioner to turn to in this time of crisis, and no provider for follow-up care after the devastating loss occurs.

Patients seek care in the ED for multiple reasons. Lack of access to primary care, inability to secure a timely doctor's office appointment, convenience, and inability to pay for care are some examples. The ED census and acuity continues to grow (ACEP, 2008). A major problem facing EDs across the United States is a lack of acute care and intensive care unit (ICU) beds available in the hospital for admitted ED patients to be transferred. This sets the stage for overcrowding of acutely ill patients in the ED with no available ICU or acute care beds in the hospital and insufficient space and numbers of health care personnel to care for these patients (ACEP). This bottlenecking can cause extreme wait times for patients, excessive stress on the staff, and a challenging environment for addressing emotional concerns of the woman and family suffering from a pregnancy loss. In order to address the complex needs of women facing a pregnancy loss, the ED staffing resources need to be evaluated and monitored for quality. Providing collaborative care in the ED requires safe and adequate staffing of

physicians, nurses, technicians, social workers, counselors, pastors or ministers, and access to an obstetric nurse. Unfortunately, in the current economic health care environment, many EDs may have limited resources as they strive to deliver holistic care to all patients.

Care of the ED Patient With Pregnancy Loss

The ED evaluation always begins with the primary survey during which all life-threatening conditions are assessed and treated. The secondary survey always follows the primary survey and includes a more detailed and focused examination with appropriate interventions and plans for discharge.

Primary Survey

The primary survey involves assessing and maintaining the patient's airway, breathing, and circulation. In assessing the circulation of the mother, checking for signs of hemorrhage is essential. The presence of moderate to heavy bleeding, severe abdominal pain, tachycardia, or hypotension signal an acute condition and a rapid obstetric consult should be obtained. In addition, other emergent causes for abdominal pain should be considered (Angelini, 2003). Pregnant patients have increased physiological reserves and increased circulating blood volume, and therefore have a better capacity to accommodate blood loss without compensatory changes in their vital signs. Therefore, they may not show signs of shock until late in their presentations (Birkhahn, Gaeta, Bei, & Bove, 2002). In addition, orthostatic blood pressure changes do not occur until 10% to 15% of blood volume is lost (Thorstensen, 2000).

While the obstetric consult is in progress, intravenous fluid resuscitation should be initiated and must continue until the source of bleeding can be discovered and corrected. If the mother's condition continues to deteriorate, blood products may be needed and emergent surgery should be considered (Coppola & Coppola, 2003; Griebel et al., 2005; Roppolo, Davis, Kelly, & Rosen, 2007).

Since an ectopic pregnancy is a potential life-threatening complication of pregnancy, any woman of childbearing age coming to the ED with abdominal pain should be considered to have an ectopic pregnancy until proven otherwise. If ectopic pregnancy is diagnosed, emergent surgery is indicated (Coppola & Coppola, 2003; Puscheck & Pradhan, 2006). Laboratory studies should be initiated during the primary assessment and should include

a complete blood count, type and cross match for blood, a urinalysis, and a baseline quantitative β -HCG with follow-up serial values (Coppola & Coppola; Tulandi & Al-Fozan, 2008).

Fetal circulation must also be assessed. Fetal heart tones may be heard with electronic devices as early as 8 weeks. The ability to auscultate the fetal heart tones can also be used to estimate the gestational age of the fetus (Davidson, London, & Ladewig, 2007). In addition, the integrity of the cervical os should be evaluated since an open cervical os is a sign of inevitable miscarriage (Griebel et al., 2005).

Secondary Survey

Once the primary survey is completed and the patient is stabilized, the secondary survey begins. This includes a complete physical assessment with a detailed history.

History

When caring for a woman who presents with concerns about her pregnancy, the history should include the following components (Davidson et al., 2007; Jordan, 2007; Kriebs & Fahey, 2006; Tulandi & Al-Fozan, 2008; Varney, 1997).

Establishment of Gestational Age

Where and how has the pregnancy been confirmed? What was the date of the last normal menstrual period? What is the estimated date of delivery? Have any ultrasounds been done during this pregnancy. If so, when, what were the results? Whether or not the client has already initiated prenatal care elsewhere is usually revealed during this line of questioning.

Pain Assessment

Pain associated with pregnancy loss varies considerably. It is important to determine the location and character of pain, onset and duration of discomfort, as well as associated symptoms. Pain is often in the suprapubic area, but can be in both lower abdominal quadrants; it may be localized or radiate to the lower back, buttocks, genitalia, and perineum. Associated symptoms may include nausea, vomiting, or fever. If the pain is unilateral, an ectopic pregnancy or a ruptured ovarian cyst can be possible causes. A ruptured ectopic pregnancy can lead to severe bleeding, shock, and even death. Due to these risks, a diagnosis of ectopic pregnancy should not be ruled out until an intrauterine pregnancy can be confirmed (Kriebs & Fahey, 2006).

Bleeding Assessment

As with pain, bleeding amount and duration varies considerably. However, the ED nurse must discern the onset, amount, and duration of bleeding. The presence of clots or other tissue is important to know. What is the color, the amount, passage of clots/tissue? Whether or not the bleeding was associated with any particular activity (intercourse, exertion, and trauma) may be helpful. The number of pads/tampons used over a specific time can help quantify the amount of bleeding. Although rare, hemorrhage is possible and it is paramount to protect the mother's hemodynamic status. It is important to save any passed tissue for pathology evaluation (Jordan, 2007).

Obstetric and gynecologic history

A detailed history that includes the number of pregnancies and a detailed history of each outcome is essential. Using the five-letter G/PTAL system, a woman's pregnancy history can be quickly summarized (Varney, 1997).

Medical/Surgical History

The client's history of medication use, allergies, illness, previous surgeries are important. In addition, a complete mental health history is critical including past or current problems with depression and/or anxiety.

Social History

Domestic violence often increases during pregnancy and must be assessed during an ED visit (Davidson et al., 2007). The Abuse Assessment Screen is a well-established tool for effective violence screening. Smoking and cocaine use are associated with spontaneous losses (Tulandi & Al-Fozan, 2008) and must be evaluated.

Physical Assessment

Following a complete history, the secondary physical assessment starts with an examination of the abdomen and pelvic structures. Although the primary survey has been conducted and the patient stabilized prior to taking the history, an abdominal examination can further identify an "acute abdomen" requiring immediate surgical evaluation. In a complete abortion, the abdomen is benign, with no distension, no rebound tenderness, normal bowel sounds, no hepatosplenomegaly, and mild suprapubic tenderness. In the first trimester, the uterus may or may not be palpable near the symphysis pubis. If the patient has rebound tenderness, rigidity or a distended uterus exists, a complete abortion

is unlikely and an ectopic pregnancy should be assumed (Puscheck & Pradhan, 2006).

Diagnostic Tests

Following the physical exam, a transvaginal ultrasound is an essential tool for evaluating early pregnancy (Tulandi & Al-Fozan, 2008). The ultrasound can help determine whether or not the pregnancy is intrauterine or ectopic and possibly identify a molar pregnancy. Subsequent laboratory work will depend on ultrasound findings.

Ongoing Care

The patient is monitored for hemodynamic stability with frequent evaluation of bleeding and vital signs while waiting for a definitive diagnosis and consultations. Intravenous fluids are administered as needed. RhoGAM should be given to all pregnant women when the maternal blood type is Rh-negative and maternal/fetal blood exposure is possible to prevent isoimmunization (Roppolo et al., 2007). Comfort measures such as analgesics, antiemetics, positioning, warm blankets, and an ample supply of obstetric pads are provided. Once the ED clinician is convinced that the patient is physiologically stable, the next step is to acknowledge and address the emotional needs following a pregnancy loss. The nurse should allow for family presence, provide access to clergy or social services if the patient desires, and begin to consider postdischarge referrals for counseling and reproductive health services (Curtis, 2007).

Emotional Impact of Pregnancy Loss

Several authors have argued that the profound emotional impact of pregnancy loss is often underappreciated by health professionals (Brier, 1999; Engelhard, 2004; Launer, 2005; Lok & Neugebauer, 2007; Thorstensen, 2000). In general, women and family members have repeatedly reported dissatisfaction with emotional support when treated for pregnancy loss in the ED (Covington & Rickabaugh, 2006; Dougherty, 1994; Lee & Slade, 1996; Moulder, 2001; Washbourne & Cox, 2003; Wong, Crawford, Gask, & Grinyer, 2003).

Women respond to fetal loss in a variety of ways ranging from feeling a minor setback to more stressful feelings of sadness, anger, guilt, anxiety, preoccupation with the loss, search for meaning, and diminished interest. The grief can be as profound as the loss of a cherished, loved, future member of the family. Although the tendency is to

focus on the mother, the father or significant other and family members may also be profoundly affected by the loss (Callister, 2006; Cumming et al., 2007; Lok & Neugebauer, 2007; Miron & Chapman, 1994; Puddifoot & Johnson, 1997; Wojnar, 2007). Miron and Chapman described men as having intense feelings of loneliness, isolation, and pain.

Risk Factors for Psychological Morbidity

Crippling psychological disorders such as severe depression and anxiety have also been reported by patients suffering from a pregnancy loss (Lok & Neugebauer, 2007). Lok and Neugebauer, Swanson (2000), and Nikcevic, Kuczmierczyk, and Nicolaides (2007) reported several risk factors associated with the development of psychological morbidity after pregnancy loss: history of psychiatric illness; lack of social support of marital stability; previous loss; extent to which the pregnancy was wanted; history of passive coping skills; emotional strength; low income; personal significance; absence of previous successful pregnancies; and finding the cause for the fetal loss.

Feelings of Guilt

Women with pregnancy loss often struggle with feelings of guilt over the loss of the child. They often blame themselves for the loss, considering all the things they might have done to exacerbate the loss (Griebel et al., 2005; Hale, 2007). In a 2007 study investigating problematic emotions following maternal grief, guilt was found to be one of four significant factors contributing to maternal grief (Barr & Cacciatore, 2007). In an effort to allay the feelings of guilt, an investigation as to the cause of the miscarriage is helpful for the mother and significant others so they can be assured that the fetal loss is not related to their actions (Brown, 2008; Nikcevic et al., 2007).

Cultural/Spiritual/Religious Considerations

Culture plays an important role in maternal reactions to loss. Most cultures highly value having children, and in these cultures, fetal loss is very significant and painful. Understanding culturally diverse practices, rituals, and the cultural meanings of loss is essential. For example, a deceased Jewish child may be named for inclusion in the family records. Native Americans are often stoic in the face of loss and grieve privately. The Chinese often express intense emotion at the time of grieving. For Mexican Americans, the family is a significant source of support in a time of loss (Callister, 2006).

Spiritual and religious feelings have also been found to play a role in grief work following a fetal loss. Mann, McKeown, Bacon, Vesselinov, and Bush (2008) found an inverse relationship between the attendance of women to religious services and the length of the grief process. Women who attended spiritual services more frequently and those who were closely aligned with an organized religion were less likely to have prolonged grief responses.

Posttraumatic Stress

Some literature is available on the development of acute psychological conditions related to fetal loss such as depression, anxiety, and prolonged grief. In the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) are described as consequences of exposure to an extremely traumatic event that arouse intense negative emotions in the person involved (American Psychiatric Association, 1994). According to Bowles et al. (2000), anecdotal evidence suggests that up to 10% of women meet criteria for ASD within 1 month of pregnancy loss and up to 1% meet the criteria for PTSD 4 weeks after the event. This suggests that ED and obstetric nurses should be aware of the potential for severe emotional distress women may have following pregnancy loss.

Depression and Anxiety

Depression and anxiety are commonly reported after pregnancy loss (Price, 2008a), and as many as one half of women reported elevated depressive symptoms after a loss (Lok & Neugebauer, 2007). Of these women, 10% to 50% were diagnosed with major depressive disorders. In an earlier study, Neugebauer et al. (1997) reported that childless women were 2.5 times more likely to experience a major depressive disorder in the 6 months following a loss, 72% of which started in the first month after the loss. In another study examining depressive symptoms and grief after pregnancy, depression was inversely related to age, with more depression exhibited when pregnancy loss occurred at younger ages (Mann et al., 2008). In the last several years, more research has begun to address the occurrence of anxiety disorders in women with pregnancy loss. Lok and Neugebauer estimated that 20% to 40% of women experience elevated anxiety symptoms following pregnancy loss. Others found that women who experienced pregnancy loss were at increased risk of anxiety symptoms immediately following the loss and continuing for approximately 4 months (Brier, 2004; Geller, Kerns, Klier, 2004). The risk for developing anxiety disorders such as obsessive compulsive disorder

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usually occurs within the first 6 months following pregnancy loss.

Encouraging data have been found about the success of decreasing depressive symptoms through the use of interpersonal counseling. Although not usually available during the ED encounter, a medical consultation that includes a discussion of possible etiologies for the loss was useful in decreasing anxiety over time (Nikcevic et al., 2007).

Recovering from the emotional aspect of pregnancy loss takes time. Since the ED nurse only sees the patient for a brief period of time, working in collaboration with obstetric nurses and social services to formulate a holistic plan of care will enhance the quality of care (Curtis, 2007).

Fetal Loss: A Collaborative Framework

Close collaboration between emergency and obstetric nurses and social service providers is critical in order to provide holistic care for patients experiencing pregnancy loss in the ED. Based on the ED and obstetric literature, a collaborative framework of care was developed focusing on the physical, emotional, and follow-up needs of the patient. The fetal loss framework addresses this collaborative effort and provides an innovative approach to providing holistic care for this population of patients. Minimal information has been found regarding treatment of the emotional aspects of pregnancy loss in the ED. A synthesis of the literature provided the foundation for the following framework that could be used by both ED nurses and obstetric nurses in an effort to move toward more holistic care for women and families experiencing loss (Brier, 1999; Covington & Rickabaugh, 2006; Cumming et al., 2007; Curtis, 2007; Griebel et al., 2005; Harrahill, 2005; Hutchon, 1998; Price, 2008a, 2008b; Thorstensen, 2000).

Fetal Loss Framework

1. Focused physical exam: Assure that a thorough history, physical, laboratory, and diagnostic evaluation is completed. Immediate

- life-saving interventions are initiated in an effort to preserve life.
2. **Early information:** Deliver the information about pregnancy loss as soon as possible using patient-centered language that avoids the term "abortion." Hutchon (1998) argued that the lay public tends to interpret abortion as an elective termination of pregnancy. Avoiding this term helps to acknowledge the loss and dispel any guilt feelings. Harrahill (2005) recommended that when breaking bad news (a) begin the interaction with a positive encounter, (b) find out how much the patient/family knows, (c) share the information, (d) respond to the patient's/family's feelings, and (e) make a plan and follow through.
 3. **TLC:** Provide comfort, empathy, and ongoing support encouraging both patient and significant others to grieve. Listening and responding to their immediate concerns is critical. Frequent priority questions include "Why did this happen" and "Will it happen again"? Nurses need to be prepared to answer those questions honestly.
 4. **Anniversary phenomenon:** Warn the patient about the "anniversary phenomenon," a reference to the increased likelihood of experiencing depressive symptoms at the same time as the loss or the expected date of delivery (Griebel et al., 2005).
 5. **Let-out feelings:** Counsel patients to communicate their feelings of loss to family and friends. Without this knowledge, family and friends may not understand the magnitude of the loss, ignore the subject or make comments that, although well-intentioned, may minimize the event (Brier, 1999; Griebel et al.; Price, 2008a).
 6. **Link-up with social worker:** The ED nurse should identify potential high-risk women and make appropriate referrals. This should be done in addition to the obstetric clinic referral for follow-up. When possible, connect patients with counselors who specialize in pregnancy loss. Nurses need to consider that significant others may also have emotional reactions that are experienced differently from the mother; therefore, they should be included when considering follow-up counseling (Brier; Cumming et al., 2007; Price, 2008a, 2008b).
 7. **Outpatient care:** Identify how and where the patient gets her care. If follow-up care has not been set up, schedule an appointment for her or supply names/numbers. If she is getting care somewhere, ask if she feels comfortable returning to the same office since returning to the same office may be stressful (Thorstensen, 2000). Ensure that the contact information for offices/clinics is available in the ED so the patient goes home with more than generic "follow up with your doctor" instructions. Provide clear discharge instructions regarding normal signs of recovery and a list of abnormal signs for which the patient should return to the ED (Zaccardi, Abbott, & Koziol-McLain, 1993).
 8. **Social support:** Inform the patient and her family about the importance of connecting with social networks such as church groups, support organizations, and grief support groups. Resources and patient handouts that have been agreed upon by a cross-disciplinary team of nurses should go home with the patient. Some social support groups include Compassionate Friends (<http://www.compassionatefriends.org>; phone 877-969-0010) and SHARE Pregnancy and Infant Loss Support Inc. (<http://www.nationalshareoffice.com>; phone 800-821-0819).
 9. **Sustained follow-up:** Arrange a follow-up within the first week. Encourage the patient to write down what she wants to discuss for that visit. For example, "Today I really want a chance to talk about the risk of this happening again" (Launer, 2005).

Care Using Fetal Loss Framework

To return to the scenario discussed earlier, after an extensive ED work-up, Terri's labs and ultrasound report confirmed a "complete spontaneous abortion"; major complications were ruled out, and she was deemed stable for discharge. She was counseled by the ED physician that the pregnancy was "no longer viable," and the physician stressed the need for a follow-up assessment of her hormone levels. She was given contact information for an obstetric practitioner and was discharged with written follow-up instructions.

This scenario would have unfolded differently had the patient been treated using the fetal loss framework. Using the framework, once Terri was triaged she was taken to a private examination room, as her condition took priority. She was given early information that her urine pregnancy test was positive and that further diagnostic testing would be done. Tests for viability of the pregnancy and hemodynamic stability were completed. Terri received intravenous fluids, analgesics, antiemetics, warm blankets, and comfort measures. The nurse provided a phone for Terri and encouraged her to call her family. Once laboratory and ultrasound tests confirmed that Terri had suffered

a spontaneous fetal loss, the obstetric service was called as well as the ED chaplain and social worker. As the ED nurse had recently reviewed the hospital's online nursing education emergency/obstetric collaborative fetal loss framework module, she/he recalled the recommended interventions and follow-up information important for caring for the patient experiencing fetal loss in the ED. The ED nurse closed the door to the exam room, sat next to Terri, and told her the results of her tests. Terri was allowed to express her feelings and ask questions while the ED nurse listened carefully. She was given a discharge packet that included an obstetric follow-up appointment and information needed to contact grief counselors and social support groups in the area. Arrangements were made for an obstetric nurse to contact Terri the next day for follow-up. Terri was discharged in stable condition. Exhausted, she made her way home and called her mother. While the pregnancy loss was devastating for Terri, she was supported in her recovery largely due to the collaborative efforts of emergency and obstetric nurses and social workers.

This fetal loss framework represents the first step in building a collaborative model of health care. More research in the area of managing fetal loss and designing collaborative health care models that break down barriers will provide further direction for holistic care for women experiencing pregnancy loss in the ED. This distressing event represented a brief moment in Terri's life. The implementation of the fetal loss framework impacted Terri and her family and assisted them to assimilate this event and move forward with their lives. An unknown author was quoted, "We do not remember days, we remember moments." As nurses, the way we shape these moments and the time we spend with mothers and their families can make all the difference.

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