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Creating a Clinical Practice Guideline for Women Who Have Had a First Trimester Miscarriage: A Psychological Aspect of Care

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CREATING A CLINICAL PRACTICE GUIDELINE FOR WOMEN WHO HAVE HAD A FIRST TRIMESTER MISCARRIAGE: A PSYCHOLOGICAL ASPECT OF CARE.

A Capstone Project Submitted in Partial Fulfillment
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Has been approved as meeting the requirements for the Degree of Doctor of Nursing Practice in College of Natural and Health Sciences in School of Nursing, Program of Nursing Practice.

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EXECUTIVE SUMMARY

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One in four women will experience a miscarriage in the United States alone (Geller, Psaros, & Kornfield, 2010). Miscarriages can cause an increased distress to the women experiencing the loss and her partner (Nikčević, Kuczmierczyk, Tunkel & Nicolaides, 2000). This type of loss is not usually talked about, leaving women in great distress and suffering alone. Currently, no clinical practice guideline exists dealing with the psychological aspects of a miscarriage and how to properly care for this population. The PICOT question that guided this capstone was: (P) In women, who have had a first trimester miscarriage, (I) does an established clinical practice guideline on how to provide compassionate follow up care (C) provide better outcomes (O) allowing for healthier coping mechanisms (T) by following the steps of the guidelines from time of miscarriage to yearly follow-up visit?

This capstone project utilized the descriptive qualitative method--which combined a literature review and interviews to prove a gap exists in care being currently provided--to create a clinical practice guideline. Eleven journal articles were utilized in the literature review. Two family practice physicians, two family nurse practitioners, two midwives, and two obstetrics and gynecology physicians were interviewed. Overall, this

capstone created a clinical practice guideline focusing on the psychological aspect of care that could be provided in any outpatient setting to deliver outstanding care to this population of patients.

Keywords: clinical practice guideline, first trimester miscarriage, grief, emotional distress, support.

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CHAPTER I

STATEMENT OF THE PROBLEM

Author's Note

I was 11 weeks pregnant when I miscarried. We were at our appointment so excited to be able to hear the heartbeat. Everything had been going as planned; morning sickness was beginning to ease up, energy was coming back, and we were falling in love with the idea of a baby due on Christmas Eve. The doctor could not hear the heartbeat with the doppler so he got the portable ultrasound. That is when he said the words that still haunt me today--there was no heartbeat.

I remember sitting up on the table too numb to feel anything. I could not believe this was happening. I was retracing my steps trying to figure out what I did wrong. I tried to hold back the tears but they just rolled right out of my eyes. Our doctor supported us as best he could by telling me this was not my fault and was explaining our next steps. We chose the surgical route as I did not have the strength to allow it to occur naturally at home.

When we checked out, the receptionist said she would cancel all of our appointments. I later received two different phone calls on follow up appointments for our baby if he still had a heartbeat. After the first call, I was hurt but figured, "Okay, they missed one." After the second call, I yelled at the lady stating, "There is no more

baby! These appointments were supposed to be cancelled." I knew I should not have gotten upset but I was grieving the loss of my son and our future.

I felt empty. I felt like I was slowly losing myself with the grief. I never knew a loss like this could have so much of an impact on me. I called to make an appointment with my doctor to get help. The lady on the phone said I could not make an appointment with him. I was shocked and asked why? She stated, "Because there was no baby, I could no longer see him." I hung up the phone and cried. I am in the healthcare field. I am a nurse. I know signs of when someone needs help. I could not get the help I needed.

The healthcare system failed me as a patient during this experience. Now that I am able to take a step back and look at this not from a grieving state, but from a state of learning, I feel the need is there. Women have shared their very similar experiences with me. I want to create a clinical practice guideline that focuses on the emotional aspect of the miscarriage. Women and their partners need to be able to grieve this loss with support.

Introduction

Background and Statistics

Miscarriage, also known as spontaneous abortion, is one of the most common complications in pregnancy where there is the loss of pregnancy before 20 weeks gestation (Nikčević, 2003). "Approximately 15-20% of all pregnancies end in miscarriage making it a global health issues affecting significant numbers of women" (Murphy & Merrell, 2009, p. 1583). In the United States, one in four women will experience a miscarriage (Geller, Psaros, & Kornfield, 2010). Causes of miscarriage vary from chromosomal abnormalities, uterine abnormalities, hormonal factors, and unknown

causes. (Nikčević, 2003). Treatment options are discussed with their physician, giving options of surgical or medical treatments (Olesen, Graungaard, & Husted, 2015). The National Clearinghouse has a guideline for the medical and surgical interventions that providers can follow ("Ectopic pregnancy and miscarriage," 2012).

Psychological Distress

Miscarriages can cause an increased distress to the women experiencing the loss and her partner (Nikčević, Kuczmierczyk, Tunkel, & Nicolaides, 2000). Miscarriage can have an increased emotional effect on women who have experienced the loss, causing depression, anxiety, grief, and, in some cases, feelings of guilt (Evans, 2012). This can cause difficulties in coping with the loss, especially when miscarriage is not a topic discussed in the United States (Geller et al., 2010). Not being able to discuss her significant loss and not having a standard of care in treatment can increase the emotional stress to the woman and her family (Geller et al., 2010). "It is a known fact that grief is possibly the most painful human experiences an individual faces during his[her] lifetime" (Kakar & Oberoi, 2016, p. 371). With this significant loss, there needs to be a clinical practice guideline in place to help these women.

Opportunity Leading to Capstone Project

The data discussed above show a population in great need of support. The number of women who have a first trimester miscarriage is astounding. Not having clinical practice guidelines focusing on the psychological aspects of care in place to help the women and her family understand the loss and how to grieve shows how much this guideline change is needed.

This capstone project created a comprehensive clinical practice guideline based on multiple research studies and discussion with providers utilizing the descriptive qualitative method. The importance of understanding each person's role in this clinical practice guideline would help provide satisfying care to both providers and patients. An advanced practice nurse could be the leader in implementing the guideline by utilizing skills learned as a nurse and providing a holistic approach to care.

Remembering to provide both physical and emotional care was important in developing this clinical practice guideline. The current clinical practice guideline "Ectopic Pregnancy and Miscarriage: Diagnosis and Initial Management in Early Pregnancy of Ectopic Pregnancy and Miscarriage" focuses on the medical and surgical options of care (2012). The guideline acknowledged this is a distressing time for women and they need to be treated with dignity and respect ("Ectopic pregnancy and miscarriage," 2012). It did not, however, describe ways to help provide care, which is where a new guideline is needed to help guide the provider in the psychological aspects of care needed.

Problem Statement

This capstone project created a follow-up care clinical practice guideline for women who have had a first trimester miscarriage in order to provide better emotional support and higher satisfaction rates of care provided. Currently, there is no set guideline encompassing all aspects of care, leaving women unsatisfied with their care and often times lost in their grief (Geller et al., 2010). This could also lead their partners to feel confused or helpless because they are not properly educated about what the woman might be experiencing. "Half of the women will suffer psychological distress following a

miscarriage" (Sejourne, Callahan, & Chabrol, 2010, p. 403). The problem question was as follows: (P) In women, who have had a first trimester miscarriage, (I) does an established clinical practice guideline on how to provide compassionate follow up care (C) provide better outcomes (O), allowing for healthier coping mechanisms (T) by following the steps of the guidelines from time of miscarriage to yearly follow-up visit (PICOT).

Literature Review

Overview

Eleven different research studies and articles were chosen to help support the argument for a protocol in follow-up care for women who have had a miscarriage. One clinical practice guideline was utilized. Databases used were CINAHL and PUBMED, and the National Clearinghouse Database. Key words used in the search engines were miscarriage, emotional support for miscarriage, and follow-up care for miscarriage. Sources were limited to full text only and multiple studies were found. No systematic reviews were found during the search.

Criteria needed for this guideline development included satisfaction of care, emotional impact and experiences women faced, development of follow-up care, and overall care the women wanted to be provided after such a loss. Each of the 11 articles showed the statistics of the number of women having miscarriages, relayed the emotional effects, and some provided solutions to care.

Overall, these articles were helpful in determining the care needed for this population and were separated into three main categories: emotional care/support, what

women wanted for care, and treatment options. These three main categories provided helpful data for the author in developing this capstone project.

What women want. The first category was developed around two studies dealing with what women wanted for care and how satisfied they were with that care. This category guided the author in understanding how important it was that women be included in the development of the guideline.

Sejourne et al. (2010) utilized a questionnaire to examine what women wanted for care by having 305 women participate in the study. The study showed how difficult it was for them to experience such a loss and how much they needed the support immediately after experiencing it (Sejourne et al., 2010):

> Little information is provided to women about miscarriages, in particular the psychological impact of losing a potential baby. The most significant psychological complication for most women was fear surrounding subsequent pregnancy along with the psychological distress provoked by the miscarriage itself. (p. 408)

Overall, the women in this study were open to psychological support and showed how important education of miscarriage was needed.

Geller et al. (2010) utilized a selection of studies to review care provided to women with miscarriage and how satisfied they were with the care provided to them during their time of loss. The authors found four categories dealt with satisfaction of care: healthcare providers, information, interventions provided, and follow-up care. This was important to note so when working on the clinical practice guideline, understanding what was expected from providers could be included. Also, they discussed why providers did certain things, which could help women understand the reason and increase their satisfaction. The studies also revealed a lot of the same treatments were not offered

to the women, which could have been a cause of the differences in level of satisfaction (Geller et al., 2010). This article helped to show that developing a clinical practice guideline that can be used across different health care systems could help provide consistent and successful care.

Treatment options. The second category helped provide information on treatment options and related to the follow-up care guideline. Three articles were utilized in this group to help determine what treatments would be included in the guideline development.

Nikčević (2003) developed and evaluated a miscarriage follow-up clinic. The different staging and development were discussed and also provided insight that the services could be provided to men as well. It was important to include the men who also had gone through the miscarriage with their partner. A doctor was confirmed by women in this development to be the sole person to provide the follow-up care (Nikčević, 2003). This author would like to examine the advanced care nurse as well in the role of follow-up care provider. Again, this proved providing emotional support was needed for women and men (Nikčević, 2003).

Olesen et al. (2015) conducted a study determining treatment options for miscarriage. The study gave women the option of medical treatment such as medications for allowing the abortion to occur at home, surgical treatment such as a curettage, and discussed follow up for each (Olesen et al., 2015). This study discussed the emotional impact and feelings toward each of the treatment options. This helped in designing the guideline based on increased education and discussion with the provider and patient by

realizing the psychological aspects of the medical and surgical options noted in their discussion.

Lastly, Murphy and Merrell (2009) observed the experiences of women in a hospital setting and provided 20 months of follow-up care. They found there were three stages in relationship to the management of care: initial confirmation of losing the baby, medical or surgical procedure, and the aftermath. These stages showed the transition of the emotional state of the women who participated in the study and gave different options to support them at each stage. This was one of the more important studies found in the literature review. Utilizing the three stages in the development of when follow up care was needed the most was an important focus during the development of the clinical practice guideline.

Emotional care/support. This last grouping had very similar information. Six studies were reviewed for this category dealing with the emotional aspects including distress, bereavement, and grief. This category was very important in showing why this guideline was needed. If the topic of miscarriage is not discussed, then women suffer in silence, which can cause even more distress.

Nikčević et al. (2000) performed a study on the emotional effects of a miscarriage and whether the women had a knowledge of why the miscarriage happened. Their results showed the overall distress level decreased with proper follow-up care including education on why their miscarriage might have occurred or just understanding some of the reasons why they could occur (Nikčević et al., 2000). This short study gave some insight on the importance of education in relationship to the levels of distress.

Frost, Bradley, Levitas, Smith, and Garcia (2007) explored bereavement needs with first trimester miscarriages. They were able to show how traumatic the loss could be for women and how much proper bereavement care needed to be provided. They also showed just how closed off the public was toward how much of a loss a miscarriage could be (Frost, et al., 2007). A clinical practice guideline would need to include a great deal of education for women and men going through the loss. The more one can understand the grieving process, the more he/she can help others break the silence. This would be a huge change in how women are treated with this type of loss.

Corbet-Owen and Kruger (2001) had a similar approach in wanting to validate what healthcare professionals can do for women who have had a miscarriage. They broke down all the emotions of pregnancy before, during, and after the loss. Corbet-Owen and Kruger also showed the emotional roller coaster one could be on while pregnant and then with the sudden loss. As a provider, it showed how to allow the patient to trust and discuss these feelings so the provider could help make recommendations for proper care. The more a patient trusts her provider, the more she will be able to open up on how she feels during the process.

Evans (2012) shared the emotional care for women who have experienced a miscarriage by describing the roles of nursing care toward the patients. Her article gave both the nurses' perspectives as well as the patients, allowing both to describe the experience. There was some discussion on how much education would help nurses care for the patient; it dealt with experience sometimes mattering more than education in providing proper care (Evans, 2012). This was important to note when creating the clinical practice guideline because staff need to be sensitive to the magnitude of the loss.

Paton, Wood, Bor, and Nitsun (1999) utilized the perinatal grief scale and the hospital anxiety and depression scale to follow up on women who had a miscarriage to assess the amount of distress. Finding a valid scale was important to development of the protocol. More research into the perinatal grief scale would be needed to see if this could apply well to all women. Guideline interventions could then be utilized based on the score and allow more personalized care and better support to the patient.

Lastly, an article by Swanson (2000) helped predict depression after miscarriage at four months and one year by utilizing the Lazarus paradigm. Swanson's study was interesting because it utilized a time frame of four months and one year for follow-up care. This could be utilized in the clinical practice guideline time table as to when follow up should occur. The tool was able to predict the percentage of women who had depression symptoms at the two timeframes.

Current Guideline

The search for a current practice guideline was needed to see if there was a need for a new guideline or if the guideline was sound. The material in the National Institute for Health and Care Excellence's (2012) guideline gives providers strong information on surgical and medical options of care, how to determine if someone has had a miscarriage, and the overall outcomes of care. This guideline had great evidence-based care on the medical aspects but had little information on providing the psychological aspect of care.

Theoretical Framework

Comfort Theory

With nursing, it is important to understand underlying nursing theory when creating a clinical practice guideline. Kolcaba's (2003) comfort theory and practice was

utilized in creating the clinical practice guideline. Kolcaba worked for many years on developing this theory, which encompasses all aspects of providing comfort:

> Comfort may be a blanket or breeze, some ointment here to soothe my knees; a listening ear to hear my woes, a pair of footies to warm my toes; a PRN medication to ease my pain, someone to reassure me once again; a call from my doctor or even a friend, a rabbi or priest as my life nears the end. Comfort is whatever I perceived it to be, a necessary thing defined only by me. (p. 1)

Background on Theory

There are three concepts within discussing comfort: relief, ease, and renewal (Kolcaba, 2003). Relief is when the comfort need is met, i.e., if a patient was cold, a blanket provided met the goal. Ease is when the person is in a state of calm. Lastly, renewal is when one overcomes the problem or pain; this is where the person has become comforted and is able to move past the hurt (Kolcaba, 2003). When developing her comfort theory, Kolcaba (2003) also found there were four contexts of comfort: physical, psychospiritual, environmental, and sociocultural. Figure 1 shows how Kolcaba created a taxonomic structure of comfort utilizing the three concepts and four contexts. This structure helped Kolcaba (2003) define comfort as follows: "Comfort is the immediate experience of being strengthened by having needs for relief, ease, and transcendence met in four contexts (physical, psychospiritual, environmental, and sociocultural" (p. 14). By understanding these concepts, anyone can provide comfort care for patients as needed.

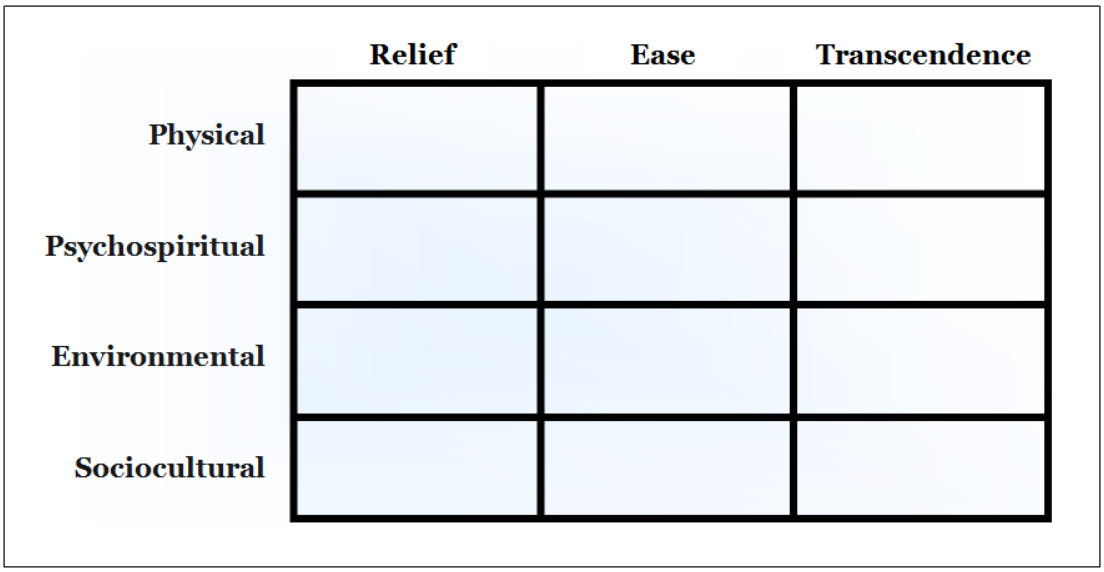

Figure 1. Taxonomic structure of comfort (Kolcaba, 2003, p. 15).

Utilization

This theory has helped the author understand the concepts when dealing with comfort. Kolcaba (2003) created different templates and survey questions to see how patients' needs had been met. She utilized physical, psychospiritual, environmental, and sociocultural concepts and developed questions to break each one down. An example was in a peri-operative questionnaire: "I was calm, I was cold, the noises were disturbing, the environment felt safe, I was not afraid to go to sleep, etc." (Kolcaba, 2003, pp. 225-226). This author made sure the clinical practice guideline dealt with all four concepts and the understanding of how to provide comfort.

Elizabeth Kubler Ross Model of Bereavement

Stages of Grief

Understanding the different stages of grief helped determine where the support is needed the most after the miscarriage. Elizabeth Kubler Ross was a Swiss-American

psychiatrist who worked with hospice patients and developed the five stages of grief: denial, anger, bargaining, depression, and acceptance (Kakar & Oberoi, 2016). These stages can be used to help understand the process of grief.

Utilization

Grief needs to be understood first before creating a clinical practice guideline to help someone through the loss of her child. A combination of the different stages of grief developed by Kubler Ross (Kakar & Oberoi, 2016 and the different stages of grief defined by the miscarriage (the first bleed, trying to get pregnant again, others around that are getting pregnant, etc.) was taken into consideration when completing the clinical practice guideline. Each stage of grief can be shown as examples in the different stages of the miscarriage and how the women are recovering.

Social Media

Support

Miscarriage can often leave a woman feeling alone due to not having anyone to turn to. Often, she feels there is no acknowledgement of this type of loss, which makes her feel like she cannot discuss her miscarriage (Rowlands & Lee, 2010): "Social support played an important role in women's miscarriage journey, with many women saying that speaking to, and gaining emotional support from others was essential" (p. 278).

With advances in technology, more people are able to turn to others on social media for support through Facebook, Instagram, Twitter, etc. (Kakar & Oberoi, 2016). When women are able to post their feelings, others with similar situations are able to acknowledge their feelings and support them through their journey. Social media has become a coping mechanism for the 21st century (Kakar & Oberoi, 2016).

When searching Facebook, one support group that also had a website allowed women to post stories of their miscarriage and how they were coping (Mothers of Unborn Angels, 2016). They provide support for anyone who has suffered a child loss including miscarriage, stillbirth, SIDs, or any other type of loss. The founder shared her story and why she created this site for others (Mothers of Unborn Angels, 2016).

Having a site like this allows others to share similar stories, comment on their posting, and help to educate and provide awareness to others who have not had this type of loss (Mothers of Unborn Angels, 2016). Teddy bears and bracelets can be purchased to show awareness of this type of loss. Currently, there are 37,225 followers and 38,849 likes of the site (Mothers of Unborn Angels, 2016).

Phenomenon

Showing one example of how people turn to social media and the internet for support provided information needed for the clinical practice guideline. It indicated many thousands of people will turn to support on the internet because there might not be other help being provided by their own providers and their offices. Some comments from different people sharing on different pages included “No one to talk to,” “Comments from people who haven’t had a miscarriage were hard,” “My loss is not a secret,” “Our baby has left an imprint on our hearts forever,” “Angel baby,” and “How will my husband be affected.” Some women shared their stories and gave examples of the follow-up care they received: “The receptionist asked me how far along I was when I was at my follow-up appointment after I had a miscarriage,” “I felt angry, and had a lot of anxiety after my loss. We didn’t tell anyone and I tried to hide it,” “I turned to different books on miscarriage,” “I can’t find the right words to share on Facebook that we lost the

baby." This is truly a phenomenon that happens through all different times in people's lives. People turn to social media for continued support over a loss, celebrate something exciting, or talk simply about their day.

Descriptive Qualitative Method

Background

Qualitative methods combine theory and experiences to develop and answer a research question (Vaismoradi, Turunen, & Bondas, 2013): **"**Qualitative approaches share a similar goal in that they seek to arrive at an understanding of a particular phenomenon from the perspective of those experiencing it" (p. 398). Qualitative research usually starts with an open-ended question that leads the researcher into a field of information on the topic (Vaismoradi et al., 2013).

Utilization

The clinical practice guideline was determined by two open-ended questions to providers and data collected on miscarriage through the literature review. The overarching question leading this qualitative research asked whether providers were providing the best evidence-based care to their patients who had had a first trimester miscarriage. Understanding how to approach this question utilizing qualitative research, helped develop themes of care and provided overall help in creating a clinical practice guideline.

Summary

One in four women will experience a miscarriage in the United States (Geller et al., 2010). Many women are experiencing this loss without proper guidelines or discussion on the topic. Many women must go through their grief in silence. This

proved the impetus for creating a proper follow-up clinical practice guideline that could provide adequate support to women and men who were affected by this loss. Compelling evidence in the literature showed the need for emotional care, what specifically women were looking for in follow-up care, and treatment options available for miscarriage. The data also reflected the significance of the loss and how much distress was caused. This capstone utilized resources in the literature review and provider interviews to create an evidence-based clinical practice guideline that would provide best practice toward follow-up care after a first trimester miscarriage.

CHAPTER II

PROJECT DESCRIPTION

Project Objectives

This capstone project had three main objectives. The first objective was to perform a literature review to determine if a significant need existed to create a clinical practice guideline for this population. Along with the literature review, different nursing theorists who could relate to this clinical practice guideline were selected. The second objective was to provide a discussion with providers utilizing the descriptive qualitative method to determine what guidelines the providers were currently following, how the care for these women was being provided, and if the women were satisfied with the care or their care was insufficient. This helped determine what goals would be met within the clinical practice guideline. The third objective was the creation of an evidence-based clinical practice guideline that would meet all goals of providers and patients and provide the best follow-up care to this population.

Project Plan

Utilizing evidence-based practice by incorporating the literature review and interviews of providers, a clinical practice guideline was created to provide best practice for women who have suffered a miscarriage. The objectives helped guide the steps of the project. First a literature review was completed that determined a great need for a clinical practice guideline. Nursing theorists were chosen based on the type of follow-up care

being provided. Next steps were to research the descriptive qualitative method and create questions to providers that would guide the making of the clinical practice guideline. Two questions were utilized in these interviews with providers. The clinical practice guideline was created once all data were collected. The guideline was reviewed by the author's chairperson and committee.

Congruence of Organization's Strategic Plan to Project

The organizations needed to implement this capstone project were determined based on the providers chosen. Some of the organizations included Banner Health and UC Health--the two main healthcare systems within northern Colorado. The University of Northern Colorado was utilized as well for the committee members. The University of Northern Colorado and a group of providers including family practice physicians, family practice nurse practitioners, midwives, and obstetrics/gynecology (OBGYN) physicians were the main organizations utilized to create the clinical practice guideline. By working together, the whole community would have their voices heard on what parts of care were most detrimental to the success of the follow-up guideline.

Timeline for Completion of Project Phases

The timelines for completion of the project were as follows:

- Summer 2016--Phenomenon of interest approved and initial proposal for project finalized. Literature review completed. Theorists discussed.
- Fall 2016--Chairperson and committee determined. Proposal started (first three chapters).
- Spring/Summer/Fall 2017--Defend proposal and Institutional Review Board (IRB) approval sought for completion of project.

- March 31, 2017--Submit proposal and complete oral exam.
- April 2017--Submit to IRB.
- May/June 2017--IRB approved project (see Appendix A). Pick theorists. Begin search for providers. Conduct project interviews and gather data.
- July 2017--Complete interviews; collect themes between interviews and literature review. Complete a clinical practice guideline.
- October 2017--Defend capstone project.
- November 2017--Submit final capstone project report to Graduate School.

This timeline was subject to change based on chairperson and committee member advice to the author on completion steps for the capstone project.

Resources

Technology was utilized heavily in this project to conduct the literature review. Providers through the specific practices agreed to work with the author within the healthcare systems mentioned above. A budget of $15 per provider (total of eight providers for a total of $120) was needed for the interviews; this was for light refreshments for the providers during the interviewing process while they were away from patient care. The timeframe for each of the provider interviews was between 30 and 45 minutes. The interviews were recorded. The data collected were typed and themes were pulled from the interviews and discussed further with the author's chairperson.

The chairperson was Dr. Karen Hessler. Drs. Kathleen Dunemn and Nancy English were the other two committee members. Kathleen Dunemn, a faculty member at the University of Northern Colorado, has extensive background in women's health. Nancy English was the outside member of the committee. She also has extensive background in women's health and loss. Dr. Hessler helped the author locate providers in the community to interview. She also helped with the data review. All three members assisted the author in developing questions and determining the number of providers needed. These three members were invaluable to this author with their expertise and compassion toward the creation of the clinical practice guideline.

CHAPTER III

EVALUATION OF PROJECT PLAN

This capstone project had three main objectives. The first objective was to perform a literature review to determine if a significant need existed in creating a clinical practice guideline for this population. The second objective was to interview providers to see what guidelines the providers were currently following, how the care to these women was being provided, and whether their care was insufficient. The third objective was to create an evidence-based clinical practice guideline that would meet all goals of providers and patients and provide the best follow up care to this population. The three main objectives were each evaluated to determine whether the objectives had been met.

First Objective

The first objective completed was the literature review to determine whether or not a clinical practice guideline was needed. After reviewing the 11 articles discussed above and the current clinical practice guideline for miscarriage, it was determined a new guideline was needed that focused on the psychological aspects of care since a significant gap in care being provided was found. Data collection was one of the most important steps to determining whether or not change was needed. During this evaluation process, the author ensured the sources were reputable, data were collected without bias, studies were backed up with evidence, and the data were able to clearly show the need for the guideline. Reviewing the current clinical practice guideline was important in determining

where the gap in care was, if providers were following the guideline, or if the guideline was not complete as to what steps the providers should take to help support their patients.

Second Objective

The interview process was important in developing what the guideline would need for both patients and providers. Eight providers were chosen for the interviews: two family practice physicians, two family practice nurse practitioners, two midwives, and two OBGYN physicians. The providers were emailed or calls were made to practices to recruit the number of providers. A copy of the email to providers is provided in Appendix B.

Two interview questions were developed by the author with assistance from the committee members:

1. What is your current practice guideline for caring for women with first trimester miscarriage?
2. If you had all the resources including time, money, and staffing, how would you create your clinical practice guideline for caring for women with first trimester miscarriage?

These questions were thought provoking in finding out the current way the providers cared for women with first trimester miscarriage and how they would actually like to practice if they had all the resources available to them. These questions allowed the providers to really share their input with the author. The interviews were recorded and the data were transcribed and entered into a data software program. The data collected showed common themes among providers. The chairperson reviewed the transcripts for further discussion of themes presented throughout the interviews. Themes from the

literature review and the interviews helped the author create an evidence-based guideline that implemented best practice in care for patients with a first trimester miscarriage.

Third Objective

This objective's goal was to create a clinical practice guideline based on the literature review and data collected from the interviews between the providers. The focus was on the psychological aspects of care for women who had had a first trimester miscarriage. The possibility of presenting the clinical guideline to the providers was determined. The main goal of this capstone project was to finalize the clinical practice guideline. Implementation of the clinical practice guideline was discussed among the committee members.

CHAPTER IV

RESULTS AND OUTCOMES

Overview of Objectives

For this capstone project, three main objectives were completed using the descriptive qualitative method. The first objective was to perform a literature review to identify a significant need for creating a clinical practice guideline to assist providers in caring for families experiencing a first trimester miscarriage. In addition to the traditional review of evidence-based literature, social media were also examined in an attempt to determine if this form of communication was used as an outlet for families grieving after a miscarriage. The second objective was to collect qualitative data from various providers caring for families who had experienced a first trimester miscarriage. The qualitative questions sought to determine what guidelines the providers were currently following, how care to these women and their families was being provided, and level of satisfaction of providers with their current care practices. Providers were also asked if they believed a gap in care existed for this population of women and their families. The third objective was to use all evidence and data collected to create an evidenced-based clinical practice guideline focused on the collective goals of providers and patients in order to work toward the goal of providing the best care to this population.

Objective One

As previously stated, the first objective of the project was to complete a literature review. The first round for the literature review was completed in the summer semester of 2016. The purpose of this literature review was to see if there was a gap in the emotional or psychological follow-up care being provided to women who had a first trimester miscarriage. In addition, the review of the literature sought to identify the possible need for a revised or newly developed clinical practice guideline for follow-up care for women who had had a first trimester miscarriage.

During continued research on the topic during the spring semester 2017, more articles were needed to show key points on social media being an outlet for people to discuss their grief and support each other. This further showed a need for more follow up care focusing on the emotional aspects of miscarriage. This population was not getting the emotional and psychological support from their own providers but from strangers online who discussed their losses as well.

The database used for this search was EBSCO HOST within the University of Northern Colorado library system. Full text criteria included key words such as "social media and loss," social media and support groups," and "social media and miscarriage." Very few articles and only one from this database were chosen to be used within this capstone project based on their relevance to miscarriage follow-up and grief. This newer phenomenon needs to be studied further on how social media could be used as an outlet for grief support. Facebook was also utilized, showing an example of a support group for miscarriage and how many members were in this group.

Theorist. In addition to the literature review, many nursing theories were reviewed to determine which could be applied within the capstone project utilizing the data collected in the literature review. Nursing theories encompass all aspects of care: physical, emotional, and psycho-social. Kolcaba's (2003) comfort theory and Elizabeth Kubler Ross's Model of Bereavement were used (Kakar & Oberoi, 2016). Understanding the different stages of grief and how to apply comfort in many different situations were considered when completing the clinical practice guideline. Understanding what we think of as little things like a blanket, temperature of a room, how someone talks to you, eye contact, etc. are what Kolcaba's theory embraces. Thus, so for this clinical practice guideline, looking at the little things women, their families, and even the providers were looking for was important.

Looking further into grief and nursing models of care, a new search began for further insight from more current theorist. Neimeyer (2017) has been researching grief since the late 1970s. He has written 30 books, 500 published articles, poetry, and is currently looking for ways to advance his theory of grieving as a "meaning-making process" (p. 1). Neimeyer was an important theorist to review for this guideline because a lot of information was gained about grief and how people can deal with grief in a healthy way.

Understanding the work of all three theorists helped this author to fully understand grief and what ways to provide comfort in order for this clinical practice guideline to become successful in helping women who have had a first trimester miscarriage. When developing the clinical practice guideline, this author felt there needed to something "big" to recommend. These theorists reminded the author that again

the little things one can do to provide comfort during a time of loss are even more important than looking for something bigger. Grief is a process; many steps must be taken to move toward peace and getting over the loss of the baby.

Social media. Use of social media as a way that women are coping with their miscarriages was examined. Not only were social media shown to be used in the way of support groups, celebrities were sharing their own personal stories or preparing meaningful songs for women to relate. One example of this is Ed Sheeran's (2011) song "Small Bump" (see Appendix C). This line-- "Cause you were just a small bump unborn for four months then torn from life. Maybe you were needed up there but we're still unaware as why"--can resonate many feelings the women wrote about within social media support groups. This author searched on Google for "songs about miscarriage" and found multiple other artists had written songs about miscarriage.

The review of social media demonstrated the importance of support groups and peer-to-peer discussions on losses they had both experienced. One woman discussed her own loss and 18 songs that were about miscarriage, loss, and how they helped her grieve the loss of her daughter:

> The poetry of music takes me places simple words can't. When I first miscarried Mara, I found incredible comfort in sound. Sound kept me connected to the outside world, preventing me from getting lost inside my head. It was a bonus when the sound was melodic or meaningful. I combed the internet for lists of songs about miscarriage or the loss of a child, and I found many gems among the lists. (Heidi, 2010, p. 1)

Multiple people commented on her posting, sharing more songs they had found and their own experiences. Another website called "Better than Eden" shared her own experience of miscarriage and allowed others to discuss their loss (Haseltine, 2015). She stated on her website:

> If you're landing on this page because you've lost a child, please know that I am so very sorry for your loss. I want you to know that I believe your loss is real and that your little one that died is just as much a unique and unrepeatable human being as any other and that his or her death is as much a loss as any other. Grieving that child is a good and appropriate thing to do and you are not alone. My hope is that some of the songs I share here will help to give words to your grief as they did for me. You may also find some help in the post Scriptures for Miscarriage as well as other things I've written on the death of a baby that you can find if you click on the Pregnancy Loss page. (Haseltine, 2015, p. 1)

Other searches brought similar results. One would post about their loss and others would comment sharing their loss, how alone they had felt, and that the posting helped them that day. It was amazing to see how much others relied on strangers posting on different avenues of social media to help them through their miscarriage. The music choices were raw, emotional, and would bring tears to your eyes reading through the pain of the artist. The comments were compassionate, honest, and transparent. The pain was unimaginable. Women who discussed their own loss did not have anywhere else to turn to but social media outlets.

Barriers. There were a few barriers to the literature review. Since this topic is more current, not a lot of articles have been written, which made the search more difficult. The 11 articles chosen were reviewed and determined to be helpful in determining there was a gap in care; however, articles written on the topic to fully understand where the gap in care was being provided were not available in the current literature. No systematic reviews were found during the search due to a lack of research focused on caring for families with a first trimester miscarriage. The lack of literature and research confirmed that a gap in care and attention to the needs of this population existed. The literature found did not offer research-based solutions on how to adequately care for families who have experienced a first trimester miscarriage.

Completion of objective one. The first objective was to complete the literature review, determine which nursing theorists could be utilized, see whether there was enough information to show there was a gap in care being provided, and the need for creating the clinical practice guideline. The methods for the literature review were discussed and 12 articles and one social media site were chosen. All showed a significant gap in care without providing any solutions or recommendations needed for follow-up care. The articles talked about what the women would want but nothing in enough detail to create a clinical practice guideline on just the literature review alone.

Institutional Review Board process. The Institutional Review Board (IRB) process was lengthy and had to be completed before the second objective could be started. First, a summary of the project per IRB guidelines was written explaining what this research study entailed: Objectives One, Two, and Three; the gap in care, interviews with providers, and the combined data to create a clinical practice guideline for follow-up care for miscarriage. A consent form was also completed by this author and is provided in Appendix D. The application was submitted for expedited review due to no direct patient contact. Two revisions were made and submitted; final approval was granted on June 10, 2017 for a one-year time period (see Appendix A).

Barriers. An important aspect of this project was keeping provider information confidential. A code was used for each provider utilizing a letter of the alphabet and the date the interview took place. The consent forms will be kept in a locked filing cabinet in the author's chairperson's office for the designated time frame required.

The IRB process took longer than expected and shifted the timeline slightly. Originally, this author wanted the approval to be completed in May 2017 so interviews

could start immediately at the beginning of June 2017 but were pushed back further into July and August 2017. The interviews should have been completed by the end of July 2017 according to the original timeline. Initial approval took about four weeks and a revision was needed. The second submission also needed changed within the documentation format. The overall barrier was knowledge based on the entire IRB process.

Completion of Institutional Review Board process. The IRB process was a great learning experience related to various research methods that could be applied and in determining which review method was required. This study required an expedited review, which resulted in maintaining the project timeline. The capstone was approved in June 2017.

Objective Two

The second objective was to collect data utilizing the descriptive qualitative method. Eight healthcare providers were interviewed to determine what guidelines were currently being implemented, how the care to these women was being provided, and to determine if the providers were satisfied with the care they were providing or if their care was insufficient. The interviews would show if a gap in care existed in the northern Colorado area.

Eight providers were divided by specialty. Having these eight views based on specialty helped encompass the entire population of providers caring for this group of women. Providers for the qualitative data were contacted by email and asked to be involved in the study (see Appendix B). The providers contacted were very interested in being interviewed and were willing to help share their knowledge. Consent forms were

completed prior to each interview (see Appendix D). Each interview was recorded and transcribed for data analysis. The interviews lasted approximately 30 minutes. Some of the interviews took place in person while others were completed on the phone per the provider's preference and availability during the time period allotted for the interview. Two main interview questions were used to collect qualitative response data:

1. What is your current practice guideline for caring for women with first trimester miscarriage?
2. If you had all the resources including time, money, and staffing, how would you create your clinical practice guideline for caring for women with first trimester miscarriage?

Follow up questions for each interview were used when appropriate:

1. Do you feel there needs to be follow-up care provided to the father of the baby?
2. What do you think about a support group?
3. What do you think about follow-up phone calls by the provider?
4. Is there anything I am missing or have not acknowledged with this interview?

Of note, the providers did need to be reminded during each interview that the focus of the questioning was on the emotional aspects of care for families experiencing first trimester miscarriage instead of the physical needs. Some participants began discussing the medical/surgical aspects of care, which was the more natural aspect of discussing follow-up care for this population. Some participants also focused on infertility, still births, and other losses. Participants seemed to carry "guilt" that they were not providing enough

care to their patients, which might need to be examined further as to why providers "burnout." These findings reflected the lack of literature on psychological aspects of care and the resultant feeling of being forgotten found on social media sites.

Once the interviews were completed, they were transcribed by the author. The providers were given codes for their interviews using a letter of the alphabet and interview date. This process continued until all eight providers were interviewed and their recordings were transcribed.

Transcriptions. Data analysis revealed several key themes within the data. Each interview had valuable data from providers that were considered when creating the clinical practice guideline. The participants were emotional when discussing the true gap in care they believed to be prevalent. Seven of the eight interviews were completed due to unsuccessfully reaching a second family practice physician willing to participate in the interview process. With the overarching responses of the seven participants, not having a second family practice physician did not affect the results. The seven transcriptions were then reviewed and three main themes emerged.

Gap in care. The first overarching theme throughout all seven interviews was a well-known gap in care when providing the emotional or psychological aspect of follow-up care for women who have had a first trimester miscarriage. All seven participants were thankful for the chance to be interviewed about this gap of care and for the opportunity to be a part of a guideline to assist providers in caring for this population. One participant stated:

> I feel so many practitioners get so caught up with the medical piece, for us the closure for us is getting the fetus out. Getting them through the next steps. We forget very often for the patient side on closure, that's not what she wants, there needs to be more emotional side, these two worlds rarely collide. Our closure is

> empty uterus, prevent hemorrhage, their world is how do we move forward and when can we try again. Those two worlds are very separate worlds.

Some participants were very emotional in describing the way care was being provided and their desire to do more for this population. One participant stated, "So I just think that the only reason I can talk about the emotional steps is because I have experienced it. Practitioners who haven't had this don't have that and can't say life after miscarriage does exist. It's hard to see in that moment." Most listed many limitations to providing adequate psychological care including insurance/current health care system rules and regulations, in-office policies of care, time in the office, and low staffing. One participant stated,

> I do think there is a gap in the support people are given and sometimes people don't reach out for help until its bad or its been too long, and they feel neglected or abandoned I really think, and they feel hopeless because, especially if you don't have a baby.

Another participant stated,

> I think it has been difficult with women since we in the office environment focus so much on the physical aspects of it like watching the HCGs and checking on the bleeding and certainly we do um monitor some of their emotional aspects but the limited time that we have in the office the emotional aspects tend to um not be addressed quite so well. So unfortunately women's emotional needs tend to not be addressed fully.

All participants agreed with this statement of focusing on the immediate physical needs of the patient.

Follow up contact. The next theme discovered was the type of follow-up contact that should be provided and by whom. All participants agreed follow-up contact was a necessary step in the care plan for families who had experienced a first trimester miscarriage. What they did not agree on was the process of how this contact would be made and who in the clinic would be the most appropriate to make it. One participant felt

very passionately that the primary care provider should be the one making follow-up phone calls to patients who had experienced a first trimester miscarriage:

> I feel the medical is clear, once you deemed the uterus is clear, you say bye see you when you are pregnant again. I feel like if time weren't an issue, if I had the ability to make this happen, I see 24 patients in a day again, I don't have time as a luxury, a simple phone call to say have you had your period, are you doing ok, are you trying again, I would do a follow up phone call. Say to the patient I am thinking about you, just wondering where you are in the process, do you need resources on depression or fetal loss. I don't feel like there is any of this at all. We could somehow build into our day, you get 20 mins to call those patients in the day. The follow up phone call would mean the world to them, it's simple for us, but it would mean the world to them. For them to think she was thinking of me.

The participant went onto state:

> I think provider. They have already bonded with that provider over the loss and they are the one who had to tell them. I think bringing in that other person rubs salt in the wound a little bit only because I don't want to say I feel bad for you but I have to bring someone else in because I don't have time for that. It should be the provider. We can offer the resources, I ask them do you want to see the social worker. We have behavioral health in house. Do you think that will help? We have a psychologist that are always in the clinic at Kaiser. So I can call them and in a drop of a hat the patient can be seen. I say hey maybe it would be good to ask how do I put one foot in front of the other today, what I can do to put one foot in front of the other tomorrow when I get out of bed, and have that brief conversation with them. I say that to my patient.

The participant felt this would provide the best support to the patient by showing the provider cared and could really assess the patient if they needed further help. The participant also felt a phone call was sufficient enough in providing emotional support for the women. Another participant stated:

> The first thing I would want is an immediate follow up appointment. I would like the minute I diagnose this, I want to see that person in the next couple of days to two weeks. Just to check in emotionally. We always do a post-partum visit after a delivery so I would want this after a miscarriage and for the patient to also have at least one behavioral health appointment or someone who takes care of emotions see them. So they can talk to someone and see if they feel talking to me is enough or if they want to continue with behavioral health. Those are the immediate things I would like to see.

Some participants agreed with her but felt a face-to-face appointment would allow better follow-up care. One participant elaborated that if someone is going to ask for help, they will more likely ask for help in person than in a phone conversation. Another participant felt that with the face-to-face contact but not giving out a pamphlet of information because she felt it made the visit generic and offensive. One participant felt the pamphlet was important because when she discussed her personal experience with a miscarriage, she felt no one talked to her husband on what depression looked like. No one had given them any information they could keep because when they were told they lost the baby they stopped listening to the information being given by the provider. One participant disagreed slightly with the use of a pamphlet:

> Sometimes when you hand someone a pamphlet the care isn't individualized and that's the flip side. Some pieces like how much bleeding is too much, or what temperature to call you. But the emotional aspects it would be harmful more than helpful if I hand them a pamphlet on emotional coping through a miscarriage that is my job to bring them through it. Instead of calling the 800 number if you are depressed. It's normal to feel depressed. That is part of our conversation on where they are at. That includes the men too, including them as well. I would not be gun hoe on handing out a pamphlet on emotional coping that would offend me.

Another participant gave an example of how their practice used both the phone call and visits to check in with the patient:

> Part of our regular post-partum is one week and six weeks. So for miscarriage it's only one more appointment. You look at that and say, wow the miscarriage situation is only doing one more half an hour visit than the normal pregnancy routine. So you have to ask the question, what is the big deal? Why wouldn't you take time and it's because most medical care are set up on a crank it through.

The participant discussed a follow up phone call one to two days after the appointment discussing the loss of the baby. Then there were follow-up visits in one week, three weeks, and at six weeks. The point of the phone call was to check in and see if they needed to be seen sooner than the one-week visit. The three-week appointment was

solely for emotional follow-up care where the three- and six-week visits were a combination of medical and emotional care. Only one participant brought up providing follow-up care like how hospice did their bereavement follow-up because this truly was dealing with a loss. The participant stated, "I would borrow a lot from hospice how they do it with the grief program. Same protocols. You have to understand my background is personal and personal relationships so medicine isn't practice that way anymore." The participant described how hospice provides follow-up phone calls, one-on-one counseling, and support groups up to the full year anniversary of the loss.

Acute versus chronic follow-up. The next theme from the data analysis was how participants evaluated medicine on an acute vs. chronic evaluation. The participants all felt follow-up care was needed solely within the first six months of being diagnosed with a miscarriage versus having follow-up care for a full year. One participant stated, "I think having it in the front end is most important. The immediate whether its one month or three months out if more needed now if a person loses a term infant then I would do the longer follow-up." The one participant talking about hospice even felt that within the first six months was sufficient. One participant discussed having the follow-up care mirror the number of post-partum visits but adding an additional one as the emotional checkup. Some participants felt if it was past the six-month mark, then they would refer the patient to another physician or social worker to help them with their grief or other psychological diagnosis such as depression or anxiety. One participant stated,

> For women's health we have so much interplay with anxiety/depression and mental health concerns. They are so common around child bearing ages and we deal with a lot, especially with a miscarriage. So If I had a perfect world I would have a therapist in the office to work with in tandem. Here is the distressed person I know, we can talk about it and come up with a care plan together so the therapist can see them. Mental health would be immensely helpful.

It was interesting to see how much they wanted to "hold" onto their patient in the beginning, almost territorial, to help them to get through that "acute" stage of grief but when the condition turned "chronic," they felt they were ready to let go of the patient and move onto finding another provider to help them. A majority of the participants felt support groups were helpful and could be looked at as more of the "chronic" follow-up approach. They felt peer-to-peer discussions--where the group has all gone through the same thing--could really help women feel heard and have a safe place to go where they could discuss all their emotions.

Barriers. Finding participants in this area was not easy. Once the participants were contacted, the response was an overwhelming "yes they would help" but scheduling appointments was difficult due to the demands of their practices. The second family practice physician interview could not be scheduled as a result of multiple unanswered requests to participate. Getting the consents signed and sent back for those who chose to interview over the phone was cumbersome. Frequent reminders and follow up-calls were labor intensive. As a result, the interview process and data collection took longer than anticipated. Providers scheduled to be on call during the interview appeared rushed in answering the questions but good conversations still occurred. The overall process of the interview was overwhelming and stressful due to not being able to get providers to answer, track their consents, and be able to interview them when they were free. Having an open schedule and flexibility on the author's part was needed to complete the eight interviews. The last three interviews were the hardest to solidify; the two midwives and the second family practice physician. Understanding the demands of a busy practice helped combat some of the barriers that made this objective difficult.

Completion of objective two. This objective was the hardest of the three objectives to complete. Trying to find participants who were free to do the interview was difficult due to the demands of their practice. However, the information received from these participants was inspiring and very helpful in creating the clinical practice guideline. The three main themes from the interviews and the major themes from the literature review were combined and taken into consideration for completing objective three.

All the participants felt there was a gap in care and wished they could do more for this population of patients. There were common themes of giving more support to the patient and being available for them emotionally whether through follow-up appointments, phone calls, or support groups. Some participants also felt there needed to be a room or communication with staff on getting the patient back into a room as soon as they arrived for the appointment. Education with staff was important in how to properly interact with patients who have had this loss. Also having a morning huddle to discuss why the patients were coming into the office was suggested because they could notify the staff. Some providers felt it was important to have someone in office who could run support groups and provide additional emotional support. Some differences would include whether the father of the baby should be supported, if the provider or a designated person should be doing the follow-up care, and how the follow-up care should be provided--whether it should be over the phone or in person and if written information like a pamphlet should be given to the patient and her family. All of these similarities and differences were considered in creating the clinical practice guideline. These

interviews truly inspired the author in a way that this project could be implemented in future practice and make a difference in this population of women.

Research validity. Qualitative research uses data collected in real world settings to understand different phenomena (Golafshani, 2003). Qualitative researchers have an important role within their studies to interview different participants pertaining to what they are researching. Two key concepts--reliability and validity--are important to review when completing a qualitative study. "Validity and reliability are two factors which any qualitative researcher should be concerned about while designing a study, analyzing results and judging the quality of the study" (Golafshani, 2003, p. 601). If a qualitative research study is reliable and has valid results, then the study is trustworthy. "Reliability and validity are conceptualized as trustworthiness, rigor and quality in qualitative paradigm" (Golafshani, 2003, p. 604).

This researcher's role was important in many ways. Having experienced a first trimester miscarriage allowed the researcher to understand why gathering this information was so important. There was some bias in the fact that quality care was not done for the researcher during her miscarriage. Also, friends/family had reached out and shared their stories of care not being made available and in the manner it should have been provided.

Being able to interview the seven providers in their different clinic settings helped provide a more detailed look into how providers were caring for this population and what they felt was missing and needed in a new clinical practice guideline. This made the data more reliable than on word alone from women within the population. Gathering data from literature and social media was also an important aspect of this qualitative study. It

brought all aspects of care together for the researcher--from literature review, coping mechanisms using social media, and the providers' opinions. This information validated the need for the creation of a new clinical practice guideline.

This study needed to be conducted as a qualitative study because data from the "real world setting" were gathered and compiled to make a clinical practice guideline. Although this guideline was not implemented during this study, the guideline was created utilizing key concepts found within qualitative research and current evidence from this population.

Objective Three

Clinical practice guideline and algorithm. This objective's goal was to create a clinical practice guideline for follow-up care for women who have had a first trimester miscarriage, focusing on the psychological aspect of care. The guideline was based on literature review data and data collected from the interviews with the providers-- the successful completion of objectives one and two. The clinical practice guideline for follow-up care for women who have had a first trimester miscarriage (a psychological aspect of care) is provided in Appendix E. The algorithm can be utilized as a quick reference guide for the clinical practice guideline (see Figure 2). These should be available to all providers. The author would be interested to see if providers would want them up at their work stations where they are documenting and getting ready for their patients. The APRN could check in with the providers on how the tool was being utilized, where the tool needed to be set out for the best visual reminder, and how the tool was working for the providers.

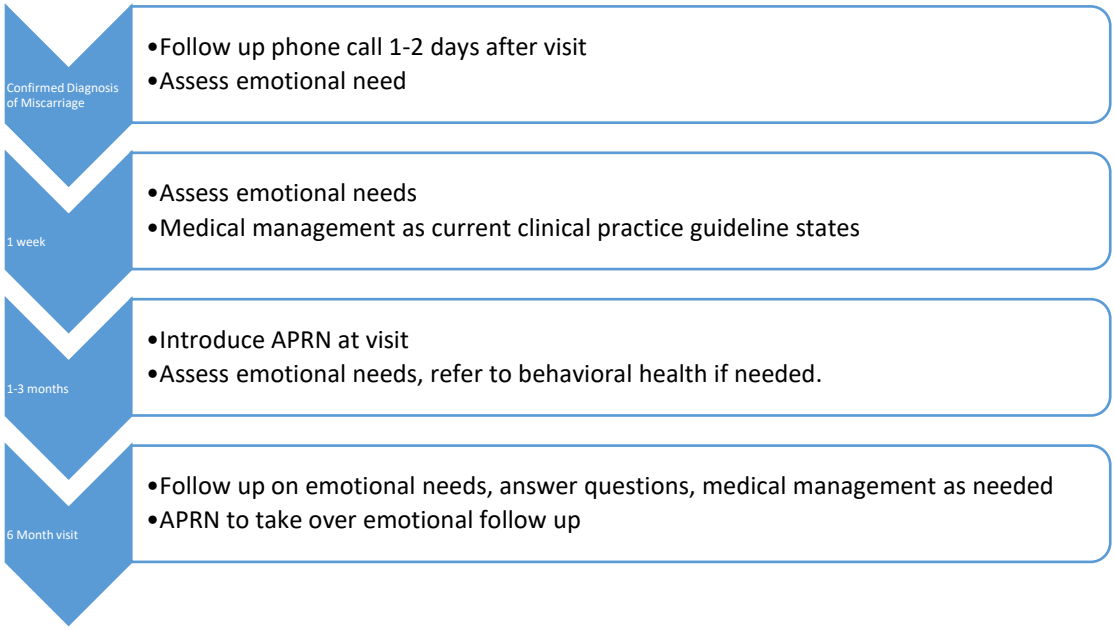

Figure 2. Algorithm to be used with clinical practice guideline.

Barriers. Creating a clinical practice guideline to be specific for all women who are going through a miscarriage is difficult. This author needed to understand that this care is so individualized and personal. This caused the greatest barrier to creating the guideline. Issues will need to be addressed as this guideline is utilized in the future by both providers and patients to determine if changes need to be made to the guideline.

Summary

The clinical practice guideline took a lot of work reviewing the literature, social media use, theorists, and provider interviews. The success of all three objectives leading to the creation of the guideline was discussed throughout this chapter. The clinical practice guideline was created with knowing that future changes would need to be made once implemented. The existing clinical practice guideline will be used in combination with this project's clinical practice guideline for a complete guide to caring for women

who have had a first trimester miscarriage. By combining the two clinical practice guidelines, it signifies the importance of all three levels of care (medical, surgical, and emotional care) being provided. Further information regarding how the guideline would be implemented in the future will be discussed within chapter five.

CHAPTER V

RECOMMENDATIONS AND IMPLICATIONS FOR PRACTICE

Summary

The clinical practice guideline was written based upon the themes from the literature and major themes from the interview process. Three main themes from the literature review were "what women want," "treatment options," and "emotional care." These themes were taken from 11 articles describing what was missing in the care being provided to women. Three main themes emerged from the interview process: "gap in care," "follow up contact," and "acute vs. chronic care."

Prior to completing the literature review and starting this project, this author felt there was a gap in care being provided to women who have had a miscarriage based on personal experience. The social media aspect of this qualitative study was also experienced during this author's personal loss. This brought about the need to investigate further to apply experience with evidence by gathering data through the literature review and provider interviews.

Overwhelming amounts of data from all parts of this qualitative study showed a gap in care being provided to this population. The author was able to show unequivocally that care was not being provided to this population and was able to develop a clinical practice guideline to help lessen the gap in the care being provided. As

a practicing family nurse practitioner, utilizing this clinical practice guideline would help provide great evidence-based care and help deliver overall patient and provider satisfaction. Most of the participants in this study were upset they did not have the resources to fix the issues identified. This clinical practice guideline outlines how to shift resources and design a program that would work for all providers caring for this population.

Not only does this clinical practice guideline affect providers but it affects families who have experienced miscarriage. The grieving process of this loss will be supported in a way they have never experienced prior to the creation of the guideline. Families will know who to turn to, understand how to grieve in a healthy way, and have a safe place to turn to with having a APRN available. This will help change the culture of how to treat women and their families during this loss. The more the APRN is able to educate families experiencing it, the more others within that community will learn about miscarriage and know what to do to help someone who is grieving.

The outcome of this study was to create the clinical practice guideline; the future of this program would be to help this population by implementing the guideline. A Doctor of Nursing Practice Family Nurse Practitioner (DNP-FNP) was designed to make changes to current policy and implement those changes utilizing evidence-based practice. This author was able to utilize that role to create changes to the current clinical practice guideline. If this guideline is followed, then the population will be cared for appropriately by looking at all aspects of care including the emotional/psychological aspects.

Five Criteria for Executing a Successful Doctor of Nursing Practice Final Project

A successful DNP project must meet five essential criteria: enhance, culmination, partnerships, implements, and evaluation **(**EC as PIE; Waldrop, Caruso, Fuchs, & Hypes, 2014). If the clinical practice guideline has fulfilled each criterion, then the pie will be complete (Waldrop et al., 2014). Not only will the pie be complete but "If a DNP student proposes a final project and its successful completion demonstrates all of the five pieces of the pie, then it will be EC as PIE to determine if the project represents work at the practice doctoral level" (Waldrop et al., 2014, p. 302). This would validate the clinical practice guideline, showing it is at the doctoral level and will make a difference when used in future practice (Waldrop et al., 2014).

- Enhance**.** This section of the pie looks to see if the project will enhance health outcomes, practice outcomes, or health care policy (Waldrop et al., 2014). The clinical practice guideline for follow-up care for women who have had a first trimester miscarriage (a psychological aspect of care) was designed based upon a literature review showing there was a gap in care being provided to this population. Interviews completed with the seven providers confirmed there was a gap in care and their suggestions were utilized to create the guideline. This clinical practice guideline was created using evidence-based practice and will be used to enhance outcomes of patients who have had a miscarriage. The clinical practice guideline is changing the policy on how to care for this population by providing more emotional and psychological support for better patient outcomes and overall patient/provider satisfaction.

- Culmination**.** This section deals with becoming an expert in the topic of choice and demonstrating the knowledge gained working on the project to show how it will change future practice (Waldrop et al., 2014). This author has had her own experience with miscarriage and follow-up care, allowing her to see the side of the patients. Certain doctoral programs show how to utilize what is learned within the required classes and how it can be applied in practice (Waldrop et al., 2014). During this doctoral program, the use of a qualitative descriptive method was discussed. Utilizing this method allowed this author to combine the literature review, nursing theory learned within the doctoral program, social media, personal experience, and provider interviews to create the clinical practice guideline. It also allowed the author to become the expert in how care should be provided within any practice setting for women who have had a miscarriage.
- Partnerships**.** The requirement of building partnerships is what describes the next piece of the pie (Waldrop et al., 2014). This author built the first partnership with her committee members. These three committee members played an important role in the completion and success of this capstone. The next partnership was built with the different providers. A trusting partnership had to be built with the providers from the very first interaction in order to allow the interviews to take place. If the providers did not feel there was a safe environment in which to discuss miscarriage follow-up, they would not have agreed to the project. The capstone project would not have been implemented if these partnerships were unsuccessful. In the

future, implementing the clinical practice guideline would again show the importance of partnerships amongst providers, staff members, and patients. The DNP role was designed so the FNP could be a leader in changing current policies and implementing good evidenced-based practice. The DNP-FNP will be able to apply changes and implement them into current practice. This clinical practice guideline could change the care in a positive way for this population.

- Implement**.** The implementation section of the pie discusses the importance of taking the evidence and applying it into evidence-based practice (Waldrop et al., 2014). It is important to gather information through various research methods but it is even more important on knowing how to take that information and put it into practice (Waldrop et al., 2014). The clinical practice guideline was designed during this capstone project. Discussion within this chapter will show how it could be implemented in the future in practice settings and by being published as a journal article to allow more providers/office managers to see how important this clinical practice guideline would be in their practice. This author needed to understand how to use the qualitative descriptive method to create a clinical practice guideline from the data collected.
- **Evaluate.** This section requires the evaluation of health care, practice, or policy outcomes by including outcomes measured within the capstone project (Waldrop et al., 2014). The outcome of this capstone was to

successfully create a clinical practice guideline for follow-up care on miscarriage that focused more on the psychological aspects of care.

Project Culmination

Being able to complete this capstone relied solely on completing the three main objectives. There needed to be literature to support the need and show a gap in care; this was completed in objective one. The second objective was to interview eight providers; two family practice physicians, two family practice nurse practitioners, two midwives, and two OBGYN physicians; this was completed utilizing seven of the eight providers needed. Objective three was to create the clinical practice guideline. This capstone project completed all three objectives by successfully creating a clinical practice guideline for follow-up care for women who have had a first trimester miscarriage with a focus on the psychological aspect of care.

Project Limitations

Depth

There were some limitations to this capstone project of creating a clinical practice guideline. This capstone was to create the clinical practice guideline without implementing it. Without implementation, a retrospective review on the effectiveness of follow-up care and patient outcomes could not be determined. An assessment tool would need to be created to evaluate whether the clinical practice guideline and the algorithm visual for providers made a difference in this population of women.

Strengths and Weaknesses

Miscarriages have been happening for many years but have not been researched to any great extent. Thus, large amounts of articles were not available for the author to

choose from for the literature review and that could have affected the outcome of this project. It showed there was certainly a gap in care being provided but would it show enough to change the mindset of a practice to implement changes needed within the guideline to provide excellent care for this population of women who were not getting the type of care needed? Having picked seven providers within this author's community, would this be enough to affect care in larger community settings? Would there be enough resources to implement the guideline? The author was only able to see the viewpoint of providers during this part of developing the guideline. Without having the women's views, there were significant limitations to what the guideline could provide. Another possible limitation was this author's bias due to personal experience with miscarriage and follow-up care that did not provide adequate support.

The study showed valid results and a draft of a clinical practice guideline was created within the limitations or weaknesses discussed above. More research and evaluation of the clinical practice guideline will be needed to show the guideline's strengths and weaknesses. The main strength of this study was how it showed the main theme of gap in care being provided to this population through both a literature review and provider interviews. Another strength was understanding Kolcaba's (2003) comfort theory and how it could apply to this clinical practice guideline. This showed the strong need for changes to be made to how care is currently being provided.

Awareness

During this investigation, it seemed there was a lack of awareness in how women's emotional care was needed along with the physical care already being provided. We as a society view discussing feelings and needing help as a weakness. Women's

health issues in general are often sorted last in the list of priorities needing attention. The key success to this clinical practice guideline would be to show providers how to critically think and offer support before someone asks for it. Providers can take away the guilt of asking for help by already providing key opportunities for women and their families to ask for help. Within the interviews, the providers felt their job was done once "the uterus was empty" but now they will understand their job is much more. The guideline also helps bring an overall awareness that a miscarriage is a loss and how important it is to acknowledge this loss.

Future Project

This goal of this current capstone project was to create a clinical practice guideline for follow-up care to women who have had a first trimester miscarriage, focusing on the psychological aspect of care. This project was completed by first completing a literature review, interviewing seven of eight providers, and writing the clinical practice guideline utilizing a combination of data collected and analyzed employing a descriptive qualitative method. A final clinical practice guideline would need to be developed for future next steps. New objectives would need to be added: objective four--to interview women who have had a miscarriage, objective five--to gather information from the seven providers on the current guideline, objective six--to make changes to the current clinical practice guideline as needed through data collection and analyzing data from objectives four and five, and objective seven--to implement the clinical practice guideline and publish it in a journal.

A retrospective nursing research study would need to be included when evaluating this clinical practice guideline. The first part of this project would be to

interview women who have had a miscarriage to discuss what their care was like, what was good about the care, what could have been improved, and what their guideline would look like. This author would also have participants review the clinical practice guideline. Combining the feedback from the women and the providers would allow this author to make further changes as needed. A specific assessment tool would need to be created to help participants evaluate the clinical practice guideline. Once this data collection took place and changes to the clinical practice guideline were made, the next step would be to find a current practice willing to implement the clinical practice guideline. Implementing the guideline would take time.

Evaluating this clinical practice guideline would be important. One way would be to design surveys for patients and providers in the practice that was piloting the clinical practice guideline. The surveys could have a list of questions asking about each section of the guideline and what they liked or saw could improve that particular section. That information would be combined to find common themes. Changes would be made to the sections and the new clinical practice guideline would be implemented. More research could be done to see if any other studies were being conducted showing new ways to provide emotional follow-up care for women who have had a miscarriage.

Summary

Implementation of this practice guideline would require a change in the model of care for woman experiencing a first trimester miscarriage. Implementing the clinical practice guideline would be the first step in achieving improvement in patient care. Learning how to apply different nursing theories to practice was an important understanding during this project. Comprehension of Kolcaba's (2003) comfort theory

would help many practitioners in caring for people who have had any type of loss, not just a miscarriage. Kolcaba's comfort theory changes the whole approach a provider has within their practice and changes the type of experience a patient has as soon as they open the door. This author truly saw this guideline as a chance to make a difference in a population that clearly has a demonstrated gap in care. No one should suffer in silence when they have a miscarriage.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

DATE:	June 12, 2017
TO:	Natalie Sheehan
FROM:	University of Northern Colorado (UNCO) IRB
PROJECT TITLE:	[1059169-3] Creating a clinical practice guideline for follow up care on women who have had a miscarriage; a psychological focus.
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED
APPROVAL DATE:	June 10, 2017
EXPIRATION DATE:	June 10, 2018
REVIEW TYPE:	Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of June 10, 2018.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

Hello Ms. Sheehan,

Thanks so much for your modifications. Your IRB application is approved and good luck with this important piece of research.

Sincerely,

Nancy White, PhD, IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX B

EMAIL SENT TO PROVIDERS

Dear _____ (provider)

My name is Natalie Sheehan. I am currently enrolled in the Doctorate of Nursing Practice program with an emphasis in Family Nurse Practitioner at the University of Northern Colorado. I am in my final year and I am currently working on my capstone project.

I have researched the topic of first trimester miscarriage and have found that there is a gap in follow up care being provided to women and their families. I would like to create a clinical practice guideline on the follow up care for women who have had a miscarriage; focusing on the psychological aspects of care.

For this capstone project, I am interviewing two family practice doctors, two family nurse practitioners, two midwives, and two obstetrics and gynecology providers. I have already completed a literature review for this project. I will be combining the data from the literature review, the current national clearinghouse guideline, and the data from the interviews to create a clinical practice guideline that helps to eliminate the gap in care being provided currently.

I was wondering if you would be interested in being interviewed by me to help create this clinical practice guideline. It would take no longer than one hour of your time which I know is very valuable. If you would like more information on my capstone project, I can forward you my proposal.

If you are interested in being interviewed please contact me at your earliest convenience to set up the interview. I appreciate your time and consideration in helping to create a clinical practice guideline for follow up care on women who have had a first trimester miscarriage.

Thank you,

Natalie Sheehan RN-BSN

APPENDIX C

ED SHEERAN LYRICS

"Small Bump"

[Verse 1:]
You're just a small bump unborn, in four months you're brought to life,
You might be left with my hair, but you'll have your mother's eyes,
I'll hold your body in my hands, be as gentle as I can,
But for now you're scan of my unmade plans,
[album version:] A small bump in four months you're brought to life
[acoustic version:] A small bump in four months you'll open your eyes

[Pre-Chorus:]
[album version:] I'll whisper quietly, I'll give you nothing but truth,
[acoustic version:] I'll hold you tightly, I'll give you nothing but truth,
If you're not inside me, I'll put my future in you

[Chorus:]
You are my one and only.
You can wrap your fingers round my thumb and hold me tight.
Oh, you are my one and only.
You can wrap your fingers round my thumb and hold me tight.
And you'll be alright.

[Verse 2:]
Oh, you're just a small bump unknown, you'll grow into your skin.
With a smile like hers and a dimple beneath your chin.
Finger nails the size of a half grain of rice,
And eyelids closed to be soon opened wide
A small bump, in four months you'll open your eyes.

[Pre-Chorus:]
[album version:] And I'll hold you tightly, I'll tell you nothing but truth,
[acoustic version:] And I'll hold you tightly, I'll give you nothing but truth,
If you're not inside me, I'll put my future in you

[Chorus:]
You are my one and only.
You can wrap your fingers round my thumb and hold me tight.
Oh, you are my one and only.
You can wrap your fingers round my thumb and hold me tight.
And you'll be alright.

[Bridge:]
And you can lie with me,
With your tiny feet

When you're half asleep,
I'll leave you be.
Right in front of me
For a couple weeks
So I can keep you safe.

[Chorus:]
'Cause you are my one and only.
You can wrap your fingers round my thumb and hold me tight.
You are my one and only.
You can wrap your fingers round my thumb and hold me tight.
And you'll be alright.

[Verse 4:]
'Cause you were just a small bump unborn for four months then torn from life.
Maybe you were needed up there but we're still unaware as why.

APPENDIX D

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH

UNIVERSITY OF NORTHERN COLORADO

Project Title:	Creating a Clinical Practice Guideline on First Trimester Miscarriage: A Focus on Psychological Aspects of Care.	
Researcher:	Natalie, RN BSN	
Phone:	(315)-750-0546	Email: Shee7328@bears.unco.edu
Faculty Advisor:	Karen Hessler, Ph.D., FNP-C, RN	
Phone:	(970) 351-2137	Email: Karen.Hessler@unco.edu

Purpose and Description: My name is Natalie Sheehan. I am a nurse and graduate student at the University of Northern Colorado. I have found a gap in care provided to women and their families for follow up care when the woman has had a miscarriage. I am interested in your current practice policies and your own personal views on how care should be provided to this population. You have been invited to participate in this study because you are currently a provider that has dealt with patients who have had a miscarriage. I hope to use this information to create a clinical practice guideline on proper follow up care utilizing your information and information from a literature review. The clinical practice guideline will be created by utilizing evidence based practice.

If you choose to participate in the study, I will ask you a few questions dealing with your current practice guideline for follow up care. Everything you say is confidential. Your patients and place of work will not be told anything you have said during the interview. No discussions with colleagues will occur as well. It should take no more than 1 hour of your time. I will be tape recording your responses, and this will be kept confidential. I will be utilizing identifiers to keep your information private. I will do everything I can to protect your identity.

I will be taking notes while talking but again will not include anything that might be used to identify you as a provider. I will also be transcribing the tape recordings. I will be using a password-protected computer that will hold the transcriptions. Your identities will be kept in a sealed envelope in a locked filing cabinet that only my advisor Karen Hessler and I will have access to. Again, no identifiers will be used to identify you as a provider. My faculty advisor will be the only one to hear the tape recording for further analysis. She will be the only person to know your identity due to collaboration on finding participants.

The risks in this study are no greater than those normally encountered during a routine discussion with other healthcare providers or colleagues. If at any point you are uncomfortable or wish to end the recording we will do so immediately. A debriefing session may occur upon request and will not be recorded.

You will not receive any direct benefit by being part of this study, however, your contributions will help to create a clinical practice guideline for follow up care for women who have had a miscarriage focusing on the psychological distress they may endure.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

Thank you so much for your willingness to participate in this interview. Your views will be utilized to make a difference in women's lives who have had a miscarriage.

_____

Subject's Signature Date

_____

Researcher's Signature Date

APPENDIX E

CLINICAL PRACTICE GUIDELINE

CLINICAL PRACTICE GUIDELINE

1. Use clinical judgment and critical thinking skills throughout this guideline when determining the correct follow-up care needed for the patient. Care should be individualized using the guideline. Not all women will need extensive emotional follow up care.
2. Educate all office staff on empathic communication, and how to handle patients who have had a first trimester miscarriage.
    a. This is to include phone call interactions, office visits, and quickly getting the patient out of the waiting room.
    b. If needed role play can help to train staff how to talk to patients who have had a loss.
    c. Educate on the 5 minute huddle of the day before patients to discuss the case load, which patients would be needing a room quickly, or taken to the APRNs office if available.
3. Designate an APRN to provide in office emotional follow up care to include;
    a. Phone calls
        i. Will need to asses needs on follow up call time frame
        ii. Need to include phone calls at 4 months and year
    b. The APRN will be in charge of running support groups
    c. Have resources available to work with the provider on providing the best care.
    d. Provide a space where patients can wait for their appointments.
    e. The APRN will need grief and bereavement educational training

4. Follow up appointments: Once loss of pregnancy if determined:
    a. Follow up phone call in 1-2 days to check in.
    b. Follow the current clinical practice guideline or office policy on the medical follow up needs i.e. how many days after the bleed or D&C etc. See Appendix D for review on the current guideline.
    c. Schedule follow up appointment at 1 week after initial diagnosis of miscarriage to assess emotional care.
    d. Schedule a follow up appointment in 1 month after the initial loss to assess how the patient is doing emotionally. Offer resources as needed. Introduce the APRN to the patient. Utilize depression screening tools such as the PHQ9. See appendix F for full description of the depression screen.
    e. Schedule a follow up visit with the APRN in months 1-3 as an additional check in emotionally based on what the patient is needing.
    f. Schedule a follow up visit within 6 months, discuss future pregnancies and any further questions. Offer the APRN as continued support and support groups offered by the APRN.
        i. If needed, provide a phone call around the year mark or due date to show continued support.
5. Provide educational resources to the public through health fairs, community centers, etc.
6. EMR changes:

a. Provide a flag on the chart of a patient who has had a miscarriage so staff scheduling or answering the phone can know to schedule that person as needed/recommended based on this guideline and the provider preference.
    i. All phone calls could be transferred to the APRN for further follow up scheduling and appointment needs.
b. Chief complaint: have a chief complaint of miscarriage instead of OB visit.