Development of a Midwifery Postpartum Clinical Guideline Following a Term Stillbirth

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Abstract

Many pregnancies and births bring joy and excitement, while some result in heartache and grief, as is often the case when the baby dies prior to labor and delivery, also known as an intrauterine fetal demise (IUFD) or a stillbirth. Midwives are closely involved in care for these women during labor and delivery, but evidence-based care guidelines specific to midwifery care during the postpartum period following a term stillbirth are limited in the literature published in the United States. Due to the limited research aimed specifically at this gap in care, a midwifery guideline was developed based on 1) a needs assessment, 2) a literature synthesis, 3) review of current guidelines from professional medical associations, and 4) input from an obstetrician-liaison and the midwives working in a U.S.-based private practice setting. By following an established term stillbirth postpartum clinical guideline, midwives can offer evidenced-based care for patients utilizing their clinical knowledge with skill, empathy, and compassion.

Key words: pregnancy, stillbirth, stillborn, fetal death, grief, perinatal loss, postpartum, postnatal, midwife, midwifery care, clinical protocols, bereavement, education, postpartum care following stillbirth, fetal demise, late stillbirth, depression, and English.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Introduction

The expectation of a new baby is typically filled with excitement and joy. Parents prepare with great anticipation for the new member of their growing family. Unfortunately, in 1 of every 167, or 5.89%, of births in the United States results in a stillbirth (CDC, 2020). Stillbirth, defined as death or loss of a baby before or during childbirth, is divided into several categories based on gestational age of the fetus at delivery. A miscarriage is typically defined as loss prior to the 20th week of gestation of pregnancy; early stillbirth is a fetal death at 20 to 27-weeks; late stillbirth is a fetal death at 28 to 36-weeks' gestation; and term stillbirth is a fetal death at ≥37 weeks of completed gestation (ACOG, 2014; CDC, 2017). The World Health Organization reports an average of 140 million births occur each year worldwide (2015), and of these 2.6 million are third trimester stillbirths with nearly half of late fetal deaths occurring in normal pregnancies (CDC, 2020; WHO, 2016). In the United States, approximately 4 million babies are born annually and approximately 24,000 babies born at late to term gestation are stillborn (Centers for Disease Control and Prevention, 2017).

In the United States, approximately 88% of births are attended by obstetricians, however midwives attend 12% of births. Physicians practice under Medical Model of Care, viewing pregnancy and birth as a pathological process (Tian et. al, 2019). Midwives, healthcare professionals who are specifically trained in pregnancy and childbirth, practice according to the Midwifery Model of Care. Certified-Nurse Midwives (CNMs) as well as Certified Midwives (CMs) have graduate level education and provide healthcare for women throughout the life cycle and practice according to the American College of Nurse-Midwives (ACMN) core competencies (ACNM, 2012). According to the core competencies and Midwifery Model of Care, the hallmark of midwifery care includes care during pregnancy, advocacy in normal processes, promotion and empowerment of women-centered care, facilitation of relationship, health promotion and disease prevention, and care for the vulnerable population (ACNM, 2012). Birth is seen as a normal life-transforming event in a woman's life and a holistic process where a relationship is built between the midwife and the woman. Midwives act as primary care providers during a woman's life cycle, including pregnancy, birth, postpartum care, and newborn care by promoting a continuous partnership of care using evidence-based models to promote healing (ACNM, 2018, n.p.). The Midwife Alliance of North America echoes this thought in their model of care which states that, "every woman deserves access to the high quality, safe, personalized, attentive, affordable, and respectful care of a midwife" (2016, n.p.).

At the time following a delivery of a term stillborn baby, most women grieve their loss by expressing depression, stress, anxiety, complicated grief, and even suicide (Mills et. al., 2014). Midwives can support women in a unique way and can offer beneficial care to recently bereaved women who are experiencing grief (Fenwick et. al., 2007). Compassionate care can positively influence the grief experience through encouragement and validation of the stillbirth experience. With use of evidence-based research, midwives can also be a part of the postpartum care in this difficult time to care for their patients. A proposed, evidence-based guideline will concentrate on the postpartum care for midwife-delivered women following a term stillbirth.

Problem Statement

The bereavement experience, during and after the event of a stillbirth, can be influenced negatively or positively by the woman-provider relationship (Grunebaum & Chervenak, 2017). Current care practices offered to women after a term stillbirth vary among obstetric providers,

including midwives (Fenwick et. al., 2007). This inconsistent follow-up may be due to a lack of standardization of care or lack of defined guidelines. Although bereavement resources are available to women immediately following delivery, an internal needs assessment at a large obstetric clinic in the Atlanta, GA area identified that no protocol exists for postpartum follow-up by midwives. Midwives can be effective in providing compassionate communication as well as physical care to bereaved women during the initial postpartum period due to the trusting relationship that is developed during prenatal care (Lunda, 2018). Assessments of an appropriate grieving process and depression can be made with more frequent postpartum visits and referrals to counselors or clergy and care can be initiated sooner, if needed. Professional healthcare support may lead to improved health outcomes (Nove, 2021). The midwives employed at the practice expressed a desire to continue postpartum care for women following a term stillbirth that they delivered. The established relationship during the woman's pregnancy enhances the role and responsibility of the midwife in meeting the woman's needs, therefore the development of a midwifery clinical guideline will facilitate midwives in caring for these women during the postpartum period following a term stillbirth.

Purpose

The purpose of this project is to develop an evidence-based guideline for a large OBGYN clinic in the Atlanta, Georgia area for best practices by midwives when caring for women fafter delivery of a term stillbirth. Midwives can be instrumental in providing physical care, emotional support, and guidance through the initial postpartum period following a stillbirth (Hutti, 2004). However, current practice standards at the clinic dictate that only physicians provide follow-up care for these women during the postpartum period. This population of women is at increased risk of depression and anxiety as well as complicated physical postpartum recovery (Loudermilk, Perry, Cashion, Alden, & Olshansky, 2016). According to *The Lance*t midwifery series, "supportive bereavement care can help families deal with their loss" (Hanzel et. al. 2016, p. 517). By developing a midwifery guideline on how best to care for women who have had a term stillbirth postpartum, the midwives at the practice will be better able to capitalize on their established connections with their patients to provide critical support in the postpartum period.

Objectives

1. Synthesize the literature related to bereavement support after a term stillbirth.
2. Review current guidelines on postpartum care for the study population published by professional medical organizations.
3. Conduct a needs assessment with practice midwives and physicians at an obstetric clinic in Atlanta, GA.
4. Develop a guideline for midwifery care following a term stillbirth that promotes support of grieving women and identification of physical care needs during the initial 6-week postpartum period.

Concepts

Grief

The term grief originates from middle Europe and is defined as "hardship, suffering, pain, bodily affliction" (Online Etymology Dictionary, n.d.). The Latin *gravare* means "to cause grief,

make heavy" (Online Etymology Dictionary, n.d.). Reactions to loss can be psychological, behavioral, social and physical (Grunebaum & Chervenak, 2017). Grief is a subjective term and is the product of one's unique experience (Ylvisaker, 2006). According to Benoliel (1976), "grief, feelings of mental suffering or sorrow, is an individual, internalized response, and thus is difficult to observe". The resolution of grief is dependent on the process of mourning, a state of behavioral change in the public setting as a reaction to grief (Grunebaum & Chervenak, 2017).

Caring

ACNM defines the concept of caring as its philosophy (2013). The role of caring, by midwives, the feeling or showing concern for or kindness to others, is to "be with women." Midwives, many of whom were nurses prior to obtaining their midwifery education, care for women through normal pregnancies as well as collaborate with obstetricians in the care of high-risk pregnancies. Caring is the essential work of a holistic practice; it is the aim of improving someone's quality of life by which nurses, including midwives, practice (Drahošová & Jarošová, 2016). Comprehensive midwifery care for women as they experience a term stillbirth is difficult and complex and requires compassionate, skillful care (Everitt, Fenwick, Homer, 2016).

Support

Support is a concept that refers to being responsive to the rights of all women to quality health care that promotes healing and health, respect of human dignity, as well as inclusion of complete information for health decisions. An effective model of healthcare promotes a partnership with the healthcare team and encourages support with high-quality, cost-effective, evidence-based care over the course of a lifetime with a healthcare provider (ACNM, 2013; Guilford, 2006).

Theoretical and Conceptual Framework of Grief and Caring

Midwives support their patients when they promote healing and health, respect human dignity, and provide complete information so that patients can make informed decisions about their health and care. Following a term stillbirth, midwives can use their caring skill to support postpartum women through their grief. Immediately after delivery, resources are available for women and their families to assist them through the steps of caring for the deceased baby and to provide information about support groups. The literature does not, however, provide an evidence-based protocol for postpartum follow-up by midwives for women following a term stillbirth (Yanti, 2015). Therefore, a clinical guideline is needed to provide a model for midwives caring for postpartum women following a term stillbirth to support women in their physical birth recovery needs, as well as their grief.

The Middle Range Theory of Caring by Kristen Swanson (1991) lays the foundation for this scholarly project. The Theory of Caring gives insight into the grieving and healing process by identifying five categories of caring: knowing, being with, doing for, enabling, and maintaining belief (Swanson, 1991, p. 163). "Knowing" focuses on understanding an event; "being with" means to be emotionally present; "doing for" is the method of caring for a woman as she would care for herself; "enabling" is guiding the patient through an unknown situation; and "maintaining belief" links faith to a difficult situation (Polit & Beck, 2004; Swanson, 1991). The theory's focus is the need for holistic care, evaluating past and future experiences. By

applying the five categories of the Caring Theory, midwives can support grieving women in a unique way, being able to empathize, support, and care.

Needs Assessment

The setting of this project was a private OBGYN practice in the Atlanta, Georgia area. Supported by the results of initial informed qualitative interviews which showed that practice midwives desired to continue care for bereaved women and families following term stillbirths, a needs assessment was conducted. The assessment of midwives of the practice gathered input on: (1) midwives' current follow-up care with their patients who had a term stillbirth; (2) perceptions on the differing postpartum treatment plans for women who delivered a viable versus stillborn baby; and (3) desires for changes to practice policies regarding postpartum care of women following a stillbirth by midwives (see Appendix A and B). The findings supported increased frequency of visits, both with physicians and midwives, which include a review of events that occurred during delivery. Midwives desired to offer postpartum care for these particular patients, believing their care will increase support and identification of depressive symptoms for the patient during this difficult time. Both the physician and midwives supported increased training for postpartum management of women who delivered a term stillborn child.

Synthesis of the Evidence

Studies Reviewed

From September to December 2016 and August to November 2021, literature searches were performed through Vanderbilt University's Eskind Library and University of North Georgia Library using the search terms: pregnancy, stillborn, fetal death, grief, a term stillbirth, postpartum, postnatal, midwife, midwifery care, clinical protocols, bereavement, education, postpartum care following stillbirth, fetal demise, late stillbirth, depression, and English. A search of CINAHL, PubMed, and Medline found studies that focused on clinical and social care for intrapartum and postpartum women who experienced a stillbirth. Articles that explored physical care were also reviewed. The Edinburgh Postnatal Depression was also reviewed. Twenty-seven articles were found that contained key inclusion criteria of gestational age at delivery, stillbirth, and midwifery care. The articles reviewed were directly relevant to care for postpartum women following a term stillbirth and varied in study design, sample, objectives, interventions, and results. The literature search inclusion criteria focused on unexpected term fetal demise, midwifery care for postpartum women following a term stillbirth, and postpartum care for women who delivered a term stillborn baby. Studies were excluded by preterm gestational age of fetal stillbirth, deliveries not attended by a midwife, and pregnancies complicated by a fetal demise due to genetic components (Ellis, 2016; Haezel et.al., 2016; Hutti, 2004, Warland & Glover, 2015). Based on the inclusion and exclusion criteria, 8 relevant studies published between 2013 and 2016, including historical literature from 1991 to 2017, were reviewed.

Interventions. Of the eight studies reviewed, all provided interventions by an interdisciplinary team caring for a patient with a term stillbirth in the inpatient setting. The interventions for term stillbirth in the inpatient setting include expeditious confirmation of a fetal demise, a plan for delivery, choice to view and hold the baby, postpartum care away from maternity floor, bereavement counseling for disposition and birth certificate, autopsy, photos and

other mementos of the baby, and referral for support groups and counseling (Grunebaum & Chervenak, 2017). Guidelines for the care of women following a stillbirth in the outpatient setting following discharge are not as clearly defined and were only mentioned by some of the 8 studies the recommended outpatient follow-up includes increased surveillance for emotional support and communication, including counseling referrals for coping with grief and depression (American College of Gynecology, 2017; Grunebaum & Chervenak, 2017; Ellis, 2016; Haezel et.al., 2016; Hutti, 2004, Warland & Glover, 2015). Physical care guidelines for postpartum management in both inpatient and outpatient settings are published and followed by the healthcare team. Interventions for physical care included in a physical assessment are vital signs, thyroid palpation, exam of the extremities, an exam of the perineum, abdomen, and/or breasts. Discussion of lactation, bleeding, and pain management is included as well. Sleep patterns are assessed. Contraception methods and resumption of intercourse are reviewed and offered, and future pregnancy planning is reviewed with the woman (ACNM, 2013; ACOG, 2016; AWHONN, 2015).

Study methods. The literature review focused on the highest quality-of-evidence studies that discussed midwifery care for term postpartum stillbirth, especially in terms of emotional and psychological support. Physical care guidelines remain the same for women following a term stillbirth. The literature reviewed included systematic reviews/meta analyses, qualitative studies, a randomized control trial (RCT), and semi-structured interviews. The criteria, or key terms, searched were selected to determine a standard care protocol for postpartum women who were cared for by midwives following a term stillbirth. Researchers in the eight reviewed studies used interviews (7), post-intervention comparisons (5), and a pre- and post-education survey (1) from a midwifery workshop to collect data about intrapartum and postpartum care for women/couples following a term stillbirth (Ellis, 2016; Haezel et.al., 2016; Hutti, 2004, Warland & Glover, 2015). Our review of the literature found that no postpartum midwifery care guideline for women following term stillbirth is currently available in the United States. Midwives desire to care for these women and are qualified, but an evidence-based guideline is not readily available (Ellis, 2016; Haezel et.al., 2016; Hutti, 2004, Warland & Glover, 2015).

Current Guidelines

Statements from national certification organizations, including ACNM, the Association of Women, Health Obstetric and Neonatal Nurses (AWHONN), and the American College of Obstetricians and Gynecologists (ACOG), were also reviewed for specific guidelines for midwifery care following a term stillbirth. All statements support increased postpartum surveillance that meets the needs of the bereaved woman by an inter-professional team following a term stillbirth (ACNM, 2013; ACOG, 2016; AWHONN, 2015). Current guidelines suggest postpartum care with continued support for women following all births.

The National Institute for Health and Care Excellence (NICE) guidelines, established for care in the United Kingdom, were also reviewed for midwifery care for women following a term stillbirth. The guidelines are used by the British healthcare system to standardize care for obstetrical and postpartum patients. While the guidelines are used as a reference in the United States, they are not the standard of care like they are in the United Kingdom. After an uncomplicated vaginal or cesarean birth, the NICE guidelines are applied and individualized to meet the needs of a mother and her baby (2015). According to NICE guidelines, care during the postpartum period should differ depending on any variation from an expected recovery after birth (NICE, 2015). For most women, the postpartum period is concluded at 6–8 weeks after the

birth, however when events occur during pregnancy or birth that are outside of the normal expected outcomes, the postpartum period should be prolonged and tailored to meet the mother's needs with support measures for improved health outcome (NICE, 2015).

The ACOG committee opinion on optimizing postpartum care also addresses the care recommended for women following a stillbirth. The ACOG position is that postpartum follow-up is essential; this care should include a physical exam, emotional support, bereavement counseling, counselor and support group referral, review of laboratory and pathology reports pertinent to the loss, as well as future pregnancy planning and instruction on risks in obstetric care. The opinion states that a primary provider should be identified for continuity of care for the postpartum woman (ACOG, 2016). Although these recommendations exist, not all providers use them consistently.

The AWHONN statement indicates that follow-up care after a stillbirth delivery is a crucial closure and may help prevent complicated grief that extends beyond the typical postpartum period (AWHONN, 2015). Symptoms to be aware of include self-blame, anxiety, and envy of others with children. Women with low self-esteem or a history of mental illness are particularly at increased risk for complicated grief (AWHONN, 2015). An interdisciplinary team of healthcare professionals can assist in the grieving process (AWHONN, 2015). The organization further states, "AWHONN (2016) supports a woman's right to choose and have access to a full range of providers and settings for pregnancy, birth, and women's health care" (p. 455).

ACNM (2013) states that postpartum care should include evaluation and management of women from a physical, emotional, mental, and psychosocial status, maternal- newborn relationship, and that appropriate education that includes breastfeeding support should be provided. National organizations support postpartum care by an inter-professional care team through increased surveillance based on the needs of the bereaved woman following a term stillbirth (ACNM, 2013; ACOG, 2016; AWHONN, 2015). Increased surveillance may increase the identification of complicated grief and may assist with the grieving process for a woman following a term stillbirth.

Findings

The current body of evidence focuses on interventions during labor and delivery for care offered by obstetric providers for women with a term stillborn baby. Physical care guidelines are comprehensive. The emotional or psychological care during the postpartum period is less comprehensive, offering basic suggestions for care, including follow-up phone calls, counseling, and support from families. The literature does not specifically focus on the care that midwives can provide based on the midwifery care model nor the ACNM core competencies. Care is directed toward obstetric providers and not differentiated specifically into midwifery care, which is a weakness in the literature as well as a gap in care. The literature does, however, acknowledge that "continuity of midwifery care was considered to be a conduit for providing quality stillbirth care, as it facilitates and enhances the mother–midwife relationship" (Everitt, Fenwick, Homer, 2016, p. 98).

Another limitation of the literature is the lack of identified interventions that are deemed best evidence in care for women following a term stillbirth. Although the results of the reviewed studies were similar in the type of interventions considered effective in care for postpartum women after a term stillbirth, no single set of care interventions grouped together was determined to be the most effective. Care protocols following a stillbirth in the outpatient setting

were not standardized. Interventions varied in timing of follow-up from phone calls to office visits, and included referrals to bereavement groups or counseling to manage grief symptoms. The Edinburg Depression Scale is available for providers and is based on evaluation of women in the previous 7 days. Midwives support women in a unique way and can offer beneficial, increased frequency care to recently bereaved women. Following a term stillbirth, a midwife's role can be the continuation of high-quality, evidence-based care for women (Ellis, 2016; Haezel et.al., 2016; Hutti, 2004, Warland & Glover, 2015), (see Appendix F Edinburg Depression Scale).

The conclusion of the review of the literature and organizational statements, care for bereaved women is not standardized and providers can broaden their care with additional resources for these patients. The current evidence on both physical and psychological management of postpartum stillbirth is limited. This gap in evidence-based care guidelines for this specific patient population is a weakness in literature. The current evidence for management of a woman experiencing a stillbirth in the inpatient setting provides detailed guidelines for care, but is not as well defined in outpatient postpartum care, especially for midwives (ACNM, 2012; ACOG, 2016; AWHONN, 2015; Ellis, 2016; Haezel et.al., 2016; Hutti, 2004; NICE, 2015; Warland & Glover, 2015). Future research can close this gap in care for term stillbirth women by identifying best evidence-based care interventions by midwives and obstetricians that improve health outcomes in the outpatient setting. Future guidelines based on rigorous research can then ensure that midwives comprehensively care for bereaved families in both inpatient and outpatient settings.

Methods

Project Design

Quality improvement (QI) methodology was used to create a clinical guideline for postpartum midwifery care at an obstetric clinic in Atlanta, GA because the purpose was to make a change in a clinical care setting. The use of the QI Plan–Do–Study–Act (PDSA) cycle will attempt to drive the proposed increased involvement in postpartum care following a term stillbirth for midwife-delivered women. The author developed an evidence-based guideline for comprehensive and consistent practice for midwives to care for this specific population of women. Upon completion of the project, the change in care can be measured by patient satisfaction surveys or quality of life outcomes after the guideline is implemented, which is not in the scope of this project. The needs assessment, literature review and statements from national certification organizations will guide the development of a clinical guideline that may be implemented at a clinic in Atlanta, GA. The outcomes of the project are measurable as based on the proposed timeline.

Sampling

The recruitment of multiple midwives and one physician for this project, a convenience sample from a large OBGYN clinic in Atlanta, GA. Midwives and a physician from a multi-location, high-volume OBGYN practice in the Atlanta, Georgia area, all of whom were female, was done by posting an initial written description of the project via email. Based on responses to the original project description, a need was identified, the focus of the project was refined to write an evidenced-based postpartum care clinical guideline for midwife-delivered women following a term stillbirth. All providers in the convenience sample provided prenatal and postpartum care in an office/clinic setting and labor, deliver, and manage postpartum patients in

the hospital at the time the project was conducted. (see Appendices A and B for the email surveys).

Plan for Implementation

The development of the clinical guideline was based on a literature review of studies, current ACNM, AWHONN, NICE, and ACOG recommendations, and the email surveys/needs assessment conducted by the convenience sample. The survey questions and answers were compared for similarities and differences, compiled into a bar graph, and then all the results were reviewed and discussed with the convenience sample physician to collaboratively develop a clinical guideline that best fit the mission of the practice. The surveys identified needs for increased frequency of postpartum visits, review of events that occurred during delivery, continuation of midwifery care postpartum, and increased need for additional postpartum training in management, including grief management, of patients who delivered a stillborn baby. Upon its completion, the convenience sample reviewed the guideline and offered additional changes and suggestions. The final suggestions and changes were addressed through revisions to the guideline by the author.

Guideline Development and Data Collection

"Qualitative research involves collecting and analyzing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences. It can be used to gather in-depth insights into a problem or generate new ideas for research" (Bhadhari, 2019). The problem of a gap in midwifery care for postpartum women following a term still birth at a large clinic in Atlanta, GA was identified and guideline development begun. Data collection for the development of the guideline involved a literature synthesis, guideline recommendations developed outside of the United States, and interview and survey results resulting in a needs assessment. The literature search was started in September 2016 and continued through May 2018, then again July 2021 to November 2021. The interviews, surveys, and scheduled meetings for the guideline development took place in March-May, 2018. Also, the concepts of grief, caring, support, depression, and stillbirth were addressed in the development of the clinical guideline. The guideline was collaboratively written with the physician-midwife liaison at two scheduled meetings with the author. Based on the physician's previous experience with bereaved women and implementation of both the medical and midwifery care models, as well as the interview/survey synthesis, a clinical guideline was developed for midwives to care for term stillbirth, midwife-delivered women at a large clinic in Atlanta GA. The synthesis and completed guideline were reviewed by the author, collaborating physician and one midwife. Per their recommendations, additions and deletions were made, and the guideline was finalized. (See Appendix E for finalized guideline)

Analysis

The qualitative data from the surveys was grouped with similar responses to the survey questions presented in a bar graph. The categories include increased frequency of visits, review of events during the delivery, midwifery follow-up, increased midwifery support, and adequate of postpartum management training. The analysis began with immersion and review survey questions presented to the midwives and the physician as part of the needs assessment. Similar ideas were grouped into five categories and again reexamined. The rationale of the categories was discussed and reviewed with the collaborating physician and suggestions were applied to

finalizing the categories. The categories identified different aspects of midwifery postpartum care for women following a birth of a term stillborn (see Appendix C).

Results

A midwifery postpartum clinical guideline was developed for use by midwives for women following a term stillbirth. This guideline was based on an evidence-based literature review and the results of a survey-based needs assessment conducted with physicians and midwives. The objectives of the project were met through a systematic process. Literature related to bereavement support after a term stillbirth was reviewed and analyzed for common themes and recommendations. Based on the evidence-based literature search, the needs assessment, review, and synthesis of current recommendations, and collaboration with a physician and midwives, a postpartum clinical guideline was developed that promotes care by midwives of the practice for midwife-delivered women following a term stillbirth. The guideline was reviewed and edited by both the physician and the midwives to meet the care process of the midwifery care model.

Discussion

The development of a midwifery guideline for postpartum care of women following a term stillbirth has the potential to improve care for a specific population of vulnerable women and to begin to close a gap in care. The guideline fulfills the purpose of the project, which was to develop an evidence-based guideline of best practices for use by midwives caring for women following a term stillbirth. Midwives practice within the midwifery care model and approach women with great understanding, empathy, compassion, and sensitivity as well as offering “high quality, safe, personalized, attentive, affordable, and respectful care” (Midwife Alliance of North America, 2016, n.p.; Sandel et al., 2015). The midwife’s focus is on teaching about pregnancy, birth, postpartum care, and newborn care that is anchored with emotional support for the woman’s transition into motherhood (Midwife Alliance of North America, 2016). The American College of Nurse-Midwives states that the model of health for a woman and her family “promotes a continuous and compassionate partnership, acknowledges a person's life experiences and knowledge, includes individualized methods of care and healing guided by the best evidence available, and involves therapeutic use of human presence and skillful communication” (ACNM, 2018, n.p.). This postpartum guideline allows midwives to be instrumental in using their clinical knowledge to effectively and compassionately care for women during the postpartum period after a term stillbirth.

The literature review found that clinical guidelines were not readily available for midwives who desire to care for this particular population of patients. Research was found where multiple interventions were used to provide care for bereaved postpartum women following a term stillbirth during the postpartum period, but none is standardized. In the review of current guidelines, including AWHONN, ACNM, ACOG, and NICE, midwifery care is not addressed specifically and offers only general guidelines for care for women following a term still birth during the postpartum period. The development of this clinical guideline addresses the current gap of a care protocol for this population of women.

The project development met some challenges along the way. The most prominent obstacle was the lack of evidence in the literature that supported midwifery care for postpartum women following a term still birth. The desire for an evidence-based tool was discussed in the

literature, but no actual guidelines had been created. An additional obstacle was the hesitancy of some midwives to discuss stillbirth deliveries. Stillbirth is part of the human experience and midwives desire to practice in a compassionate manner with proper preparation to care for women following a term stillbirth. With the guideline that includes tools and resources, a best-practice approach can be used by midwives for effective, evidence-based care for women who deliver term stillborn babies.

Conclusion

Specialized care for women during the postpartum period following a term stillbirth is recommended, and is multifaceted. Physical care is expected by providers and patients, but emotional care is a crucial aspect of holistic, comprehensive care. Women who face the difficult circumstance of a stillbirth can benefit from additional support from their providers. Midwives can be instrumental in providing emotional support and guidance for women during the initial postpartum period following a term stillbirth (Hutti, 2004). A comprehensive and compassionate midwifery guideline promotes both physical and emotional support for women in their grief following hospital discharge after a term stillbirth.

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Appendix A

Needs Assessment-Physician Interview

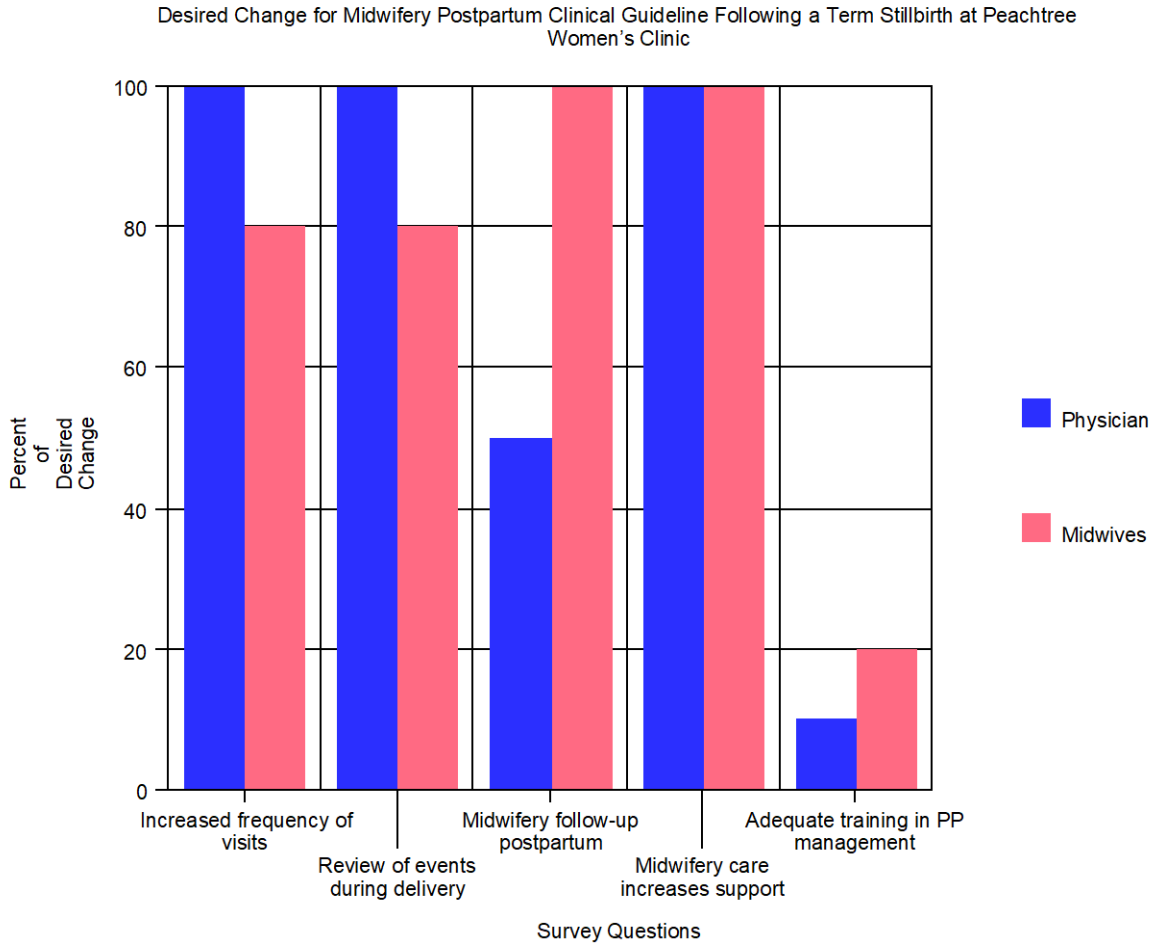
1. How do you manage women who delivered a term stillbirth during the initial 6-week postpartum period? How frequently do you contact the women who delivered a term stillbirth? How frequently do you feel they should be seen in the office during the postpartum period?
2. Do you think women who delivered a term stillborn baby should be seen more frequently than those who delivered viable babies?
3. What is the most significant topic to discuss with these women?
4. From a physician's perspective, do you think the women could be seen by the midwives during their initial 6-week postpartum period?
5. When cared for during the postpartum period, how could care be provided differently by the midwives of the practice?

Appendix B

Needs Assessment-Midwife Survey
(Verbal consent obtained by each participant)

1. How is management of the initial 6-week postpartum period for women who delivered a term stillbirth done? How frequently are the women seen? How frequently do you feel they should be seen in the office?
2. Do you believe they should be seen more frequently than those women who delivered viable babies? And if so, why?
3. What is the most significant topic to discuss with the women following a term stillbirth?
4. Do you think the women should be seen by the midwives during their initial 6-week postpartum period? Do you think midwifery care would be beneficial to these women following a term stillbirth during the postpartum period?
5. What do you think is the most important aspect of midwifery that would be considered a benefit for these women/for the practice?
6. What do you believe would be the outcome of midwifery postpartum care for women following a stillbirth during the initial 6-week postpartum period?
7. What specific topics do you believe should be discussed?
8. Do you feel adequately prepared to discuss grief and available referrals with these patients?
9. Do you believe you would be a better resource for the women when following evidence-based guideline for postpartum care following a term stillbirth?
10. Do you have any other suggestions for the development of the clinical guideline?

Appendix C



This bar graph is a summary of categories of questions that were presented to one physician and 8 midwives at an Atlanta, GA area clinic based on an identified need in midwifery care. The broad categories are:

1. How do you manage women during the initial 6-week postpartum period with delivered a term stillbirth? How frequently do you see them? How frequently do you feel they should be seen in the office?

2. What is the most significant topic to discuss with the women?

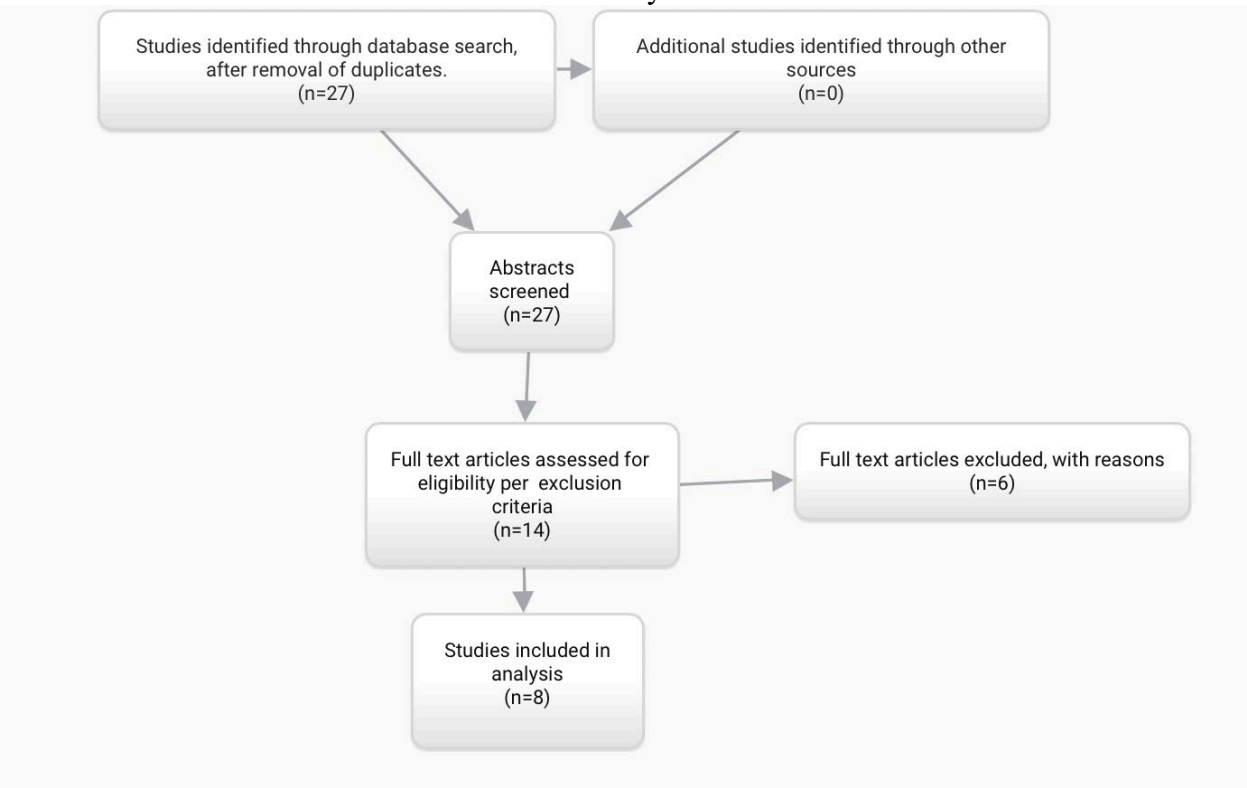
3. Do you think the women could be seen by the midwives during their initial 6-week postpartum period?

4. What could improve support in care for these women with the midwives of the practice?

5. Do you feel adequately prepared to discuss grief and available referrals with these patients?

Appendix D

Literature Synthesis



Inclusion criteria: gestational age at delivery, stillbirth, unexpected term fetal demise, and midwifery care for postpartum women following a term stillbirth.

Appendix E

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression

Postpartum depression is the most common complication of pregnancy. The Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases, it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 510 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater Always look at item 10 (suicidal thoughts)

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.