



## Patient perspectives of pregnancy loss in the emergency department

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### ABSTRACT

**Objectives:** While threats to pregnancy such as vaginal bleeding are common, half will miscarry. The ED environment is not always conducive to the emotional and psychological needs of women grieving the loss of a pregnancy. Healthcare providers have a great impact on the women's experience of pregnancy loss. This study describes the perspectives of women experiencing a pregnancy loss in the ED.

**Methods:** The study used a qualitative descriptive research design interviewing women diagnosed with a pregnancy loss in the ED. Data analysis consisted of descriptive statistics of the sample and content analysis of interviews.

**Results:** Eight participant interviews generated five themes related to the ED as part of the crossroads of motherhood and pregnancy loss. The themes were (a) Decisions to get help, (b) The environment of emergency care, (c) Not knowing, (d) Finally knowing and moving on, (e) Assisting with the grieving process.

**Conclusions for practice:** Understanding the needs of women diagnosed with pregnancy loss allows emergency nurses and providers to provide more holistic, compassionate care. Knowledge of pregnancy loss experiences will assist in the improvement of future patient care, and may positively impact recovery and transition to normalcy.

### 1. Introduction

By age 39, 25% of women will experience a pregnancy loss [1]. The majority of these pregnancy losses occur within the first trimester [2–4], often before the woman can establish a first obstetrics appointment. Vaginal bleeding during early pregnancy affects approximately 21–31% of all pregnancies [2,5–7], and of these pregnancies, 50% experiencing bleeding will miscarry [8]. Loss of a pregnancy can be an emotional, life-changing experience that leaves deep impressions on a woman's perception of healthcare experience.

The hurried and crowded ED can be an intimidating place, especially when a pregnancy is threatened. In the ED there is often a sense of chaos. The noise from cardiac monitors, ambulance sirens, overhead paging systems, and medical personnel tending to emergent situations can be overwhelming; most patients experience a high level of anxiety in the ED [9]. This fast-paced, hectic department is where the women, who may be frightened due to bleeding or pain with their pregnancy, frequently arrive and seek treatment for their unborn child. Each year, approximately 500,000 women in the United States alone seek ED care for a threatened pregnancy [8], and about half of these will end in pregnancy loss [5]. Healthcare providers have a great impact on the experience of pregnancy

loss [10,11]; however, little is known about healthcare provider and patient interactions when pregnancy loss is diagnosed in the ED. Often to individuals without personal experience, pregnancy loss is perceived as a medical diagnosis instead of a death. Women state they feel abandoned by healthcare providers who discredit the symptoms of pregnancy loss [12]. Women's satisfaction with their healthcare after a pregnancy loss is correlated to providers' recognition of the importance of this life event [13]. Physicians and nurses have been criticized for giving incomplete, insensitive care for women often due to a lack of education for the provider [14–18]. This perceived insensitive care can lead to lower satisfaction among patients, and low satisfaction with care during pregnancy loss has been associated with depression [19].

Patient experience is known to drive many aspects of healthcare. Knowledge of patient perspectives of ED care can lead to development of patient-oriented interventions to improve care and long-term outcomes. Because care providers may perceive a pregnancy loss as less severe than a potential stroke, heart attack, or other threat to life [20], the women may feel that their care was compromised and the lives of their babies were lost due to lack of attention by healthcare providers. The purpose of this study is to describe the contemporary perspectives of women experiencing a pregnancy loss in the ED.

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## 2. Methods

### 2.1. Study design

The study used a qualitative descriptive research design, employing a naturalistic inquiry approach, collecting qualitative and quantitative data [21]. This is a beneficial design as it allows the investigators to collect data directly from the voice of the participants, as well as describe the quantitative data gathered. This study was approved by the institutional review board.

### 2.2. Community advisory panel

Due to the sensitive nature of the research, a community advisory panel (CAP) of four women was formed prior participant recruitment to understand the study population needs and provide compassionate recruitment. Panel members were recruited using flyers posted in gynecology clinics and around the university campus. The panel's inclusion criteria were receipt of emergency care for a pregnancy loss in the past five years. The CAP met to discuss the demographic questionnaire, the Edinburgh Depression Scale, and the interview guide. They gave suggestions on recruitment as well as the interview guide such as verbal approach of potential participants and ordering of questions. These suggestions then were used to guide recruitment and data collection.

### 2.3. Setting and sample

From June 2016 through January 2017 women were recruited after a visit at one of two Midwestern U.S. hospitals after a confirmed diagnosis of pregnancy loss during their ED stay. Participants were recruited from two sites: one a large, urban, academic Level 1 Trauma Center ED, and the other a suburban academic Level 3 Trauma Center ED both verified by the Committee on Trauma of the American College of Surgeons [22]. These sites provided access to diverse populations and socioeconomic statuses within a region and were within the same healthcare system. All women who had experienced a pregnancy loss diagnosed in the ED were considered for participation. To be included in this study, participants must be between the ages of 18 and 45, diagnosed in the ED with a confirmed pregnancy loss, and discharged home to self-care from the ED. The study exclusion criteria were: (1) limited English or Spanish proficiency, (2) cognitive impairment as identified by the ED physician, (3) induced abortion, (4) history of invasive fertility treatments, (5) history of more than two pregnancy losses, and (6) risk for depression.

### 2.4. Data collection

Upon discharge from the ED, all discharging nurses were prompted by the electronic medical record to screen potential participants for willingness to be contacted at home to participate in this research study [23]. Chart reviews were completed by the first author, confirming inclusion criteria for women who had a pregnancy loss diagnosis and had agreed to be contacted for the research study. They were then contacted by phone within 72 h of discharge from the ED, and scheduled for an in-depth, semi-structured one-on-one interview within two weeks of the visit. Employing a consecutive sampling strategy, all eligible participants were approached for enrollment until thematic saturation was achieved.

Prior to the interview beginning, the study procedures including risks and benefits were explained, participant questions were answered, and informed consent was obtained. Next, the participant completed the Edinburgh Post-Natal Depression Scale [24] as well as a demographic questionnaire. This scale consists of 10 questions with results ranging from 0 to 3, measuring several symptoms of clinical depression including difficulty sleeping and guilt. If the score was greater than 13, this signaled a greater risk for depressive episode. The researcher

discussed this score with the woman, ensured safety, and provided additional sources for follow-up care. Study participation was terminated to prevent possible emotional distress. If the score was less than 13 the study procedures continued, focusing on the personal experience of pregnancy loss diagnosed in the ED. A semi-structured interview guide was used (Appendix A), to increase the likelihood that all the participants received the same crucial questions during their interview. The interviews were all in the English language, lasting between 30 and 60 min, were audiotaped, and subsequently transcribed. Transcripts ranged in length from 10 to 20 pages.

### 2.5. Data analysis

Two of the authors (data analysis team) independently read through the interviews and analyzed transcripts using open coding technique while exploring the experience of the women in the ED. This preliminary analysis required careful examination of the data, making notes in the right margin of the transcript. This is referred to as the first cut, developing coding categories [21]. Next, the data analysis team again independently read through the transcripts and systematically coded the data, writing the codes in the right margin. Important statements were grouped to develop the first level of coding. Then together, the team met to agree on the first level of coding and eliminate redundancies to develop a coding schema. Line-by-line each transcript was analyzed and coded per the developed coding schema, continually comparing to previous transcripts. In the next phase of analysis, each code was sorted into abstract categories and agreed on by all authors. After five transcripts were coded, all categories were identified. Recruitment was continued, and after eight interviews no new findings were discovered, and data saturation was achieved. Finally, critically evaluating each of the categories, the data analysis team determined emerging themes from the data. Theme evolution from categories is depicted in Fig. 1. Member checks then were used by consulting the CAP to review the themes that resulted from the data analysis. The authors chose to use the CAP for member checks to minimize participant burden with several follow-ups to increase the trustworthiness of the study findings with other women with similar experiences (i.e., pregnancy loss).

### 2.6. Trustworthiness

The criteria for assessing methodological rigor in qualitative research were outlined in four aspects of trustworthiness: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability. Credibility is related to how truthful research findings are, and is often used in replacement for internal validity in qualitative research [25]. This was achieved through member checks and ensuring the sample knows the phenomenon through personal experience, strictly adhering to the inclusion and exclusion criteria. Transferability is considered to be the degree to which this study's results can be applied to another sample of the same population [25]. To assist transferability, an in-depth description of the study sites and sample description were provided (Table 1). In order to provide dependability, an audit trail was developed during data analysis. To ensure confirmability, the audit trail was kept and member checks were used to validate the themes.

## 3. Results

### 3.1. Description of the sample

Eight women between the ages of 21 and 34 were interviewed about their experiences of pregnancy loss in the ED. The results of their demographic surveys are described in Table 1. Four participants were of African American descent and four were Caucasian. The majority of the women (n = 5) had never experienced a pregnancy loss before the current one, one participant experienced a single pregnancy loss

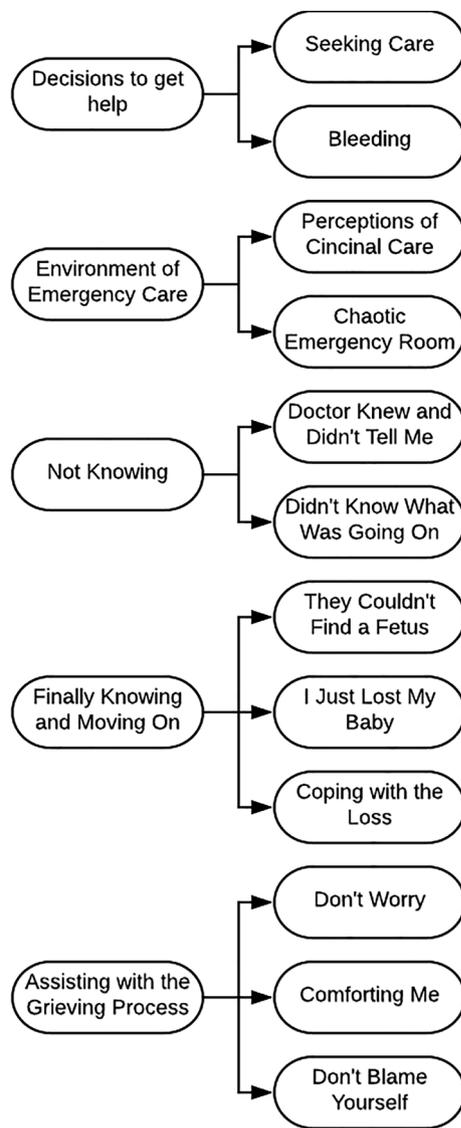


Fig. 1. Thematic diagram. ED as part of the crossroads of motherhood and pregnancy loss.

Table 1  
Sample description.

Category	Classification	Sample
Age (range 21–34)	20–24	3 (37.5%)
	25–29	2 (25%)
	30+	3 (37.5%)
Race/Ethnicity	African American	4 (50%)
	Caucasian	4 (50%)
Edinburgh depression score	0–5	3 (37.5)
	5–10	4 (50%)
	10–12	1 (12.5%)
Pregnancy loss a significant impact on your life?	Not really	2 (25%)
	Mostly	5 (62.5%)
	Very much	1 (12.5%)
Satisfied with ER care?	Not really	1 (12.5%)
	Mostly	4 (50%)
	Very much	3 (37.5%)
Number of previous losses	0	5 (62.5%)
	1	1 (12.5%)
	2	2 (25%)

previously, and two had experienced two prior pregnancy losses. Participant’s Edinburgh scale scores ranged from 1 to 12 with half (n = 4) of the sample scoring between 5 and 10. Three potential participants

were excluded due to Edinburgh scores above 13. Additionally, six of the participants stated this pregnancy loss had a significant impact on their life, and seven stated they were “mostly” or “very much” satisfied with their ED care.

### 3.2. Findings from the interview transcripts

From the analysis of the eight transcripts, 14 categories were developed and then subsequently clustered into five themes (Fig. 1). The themes that emerged from the data were (a) Decisions to Get Help, (b) The Environment of Emergency Care, (c) Not Knowing, (d) Finally Knowing and Moving On, and (e) Assisting with the Grieving Process.

#### 3.3. Theme 1: Decisions to get help

There were two categories of data coded that related to women’s decision to get help for this pregnancy. **Seeking care** was the first category, and this category represents women realizing there is something wrong and seeking out medical help. Seeking care consisted of going to the ED or calling the 24-hour pregnancy hotline. One woman, describing her decision: “I decided to wait for at least a little while. So at 8, about 8 PM, I changed one pad...it got even scarier, and I decided to go to the hospital.” The second category was **bleeding**. This category depicts the symptoms and situations surrounding when women realized something was wrong. Women described their experiences of bleeding that caused them to get help for the pregnancy: “I was at work, and I was, started bleeding a little bit and passing some clots but it was just like a period...I started cramping a little bit and bleeding a little bit more, but on Tuesday it was like really intense, the cramping was really bad, and I was bleeding a whole lot um, and I was passing more clots and bigger ones.”

#### 3.4. Theme 2: The environment of emergency care

Two categories emerged referring to the Environment of Emergency Care. One category, **perceptions of clinical care** discusses women’s perceptions of the care they received from their healthcare providers, including anticipating needs. Some women discussed a lack of privacy with their care, while other women discussed that the healthcare providers just didn’t get it when referring to their miscarriage symptoms: “It’s like I’m not going to put on a robe and walk down the hallway...I didn’t think that they realized that when you ask someone to go to the restroom, then you have to give them a pad. Like I had to ask for like six pads. Like they didn’t know, they didn’t get it.” The participants described the second category as a **chaotic emergency room**. Some women said that a lot was going on that day with lots of people coming in and out. Participants refrained from asking anyone anything because they didn’t want to bother the busy nurses. One woman stated: “Kinda seem chaotic, little bit like a lot of people coming in and out. And lot of people are frustrated. Like this guy in the room next to me came in and he was so pissy drunk he didn’t even know he was at the hospital. Like he’s peeing all over the place so that the nurses are getting frustrated and it was just a lot. It seem like a lot going on that day.”

#### 3.5. Theme 3: Not knowing

There were four categories that the women described all relating to not knowing whether they had lost the pregnancy. One category, **doctor knew and didn’t tell me**, occurred when the woman perceived that the healthcare providers knew they were having a miscarriage but didn’t tell, couldn’t tell, or never really explained what was happening. One participant described her perception: “They did the ultrasound too, and they was talking amongst each other, didn’t really tell me, you know like ‘oh this is what we see and this is what’s going on.’...They were talking amongst each other like ‘well maybe this is this, and this is that’ when they could have been telling me too.” The second category within this theme was **didn’t know what was going on**. This occurred when the women

and/or the healthcare workers felt confusion or didn't know what was happening. One woman stated: *"they was kinda like scaring me because... it was too many doctors coming in there like trying to figure out what's going on."* This also referred to when she went to another healthcare provider and was not diagnosed with a loss, but later found out she lost the pregnancy. A third category, **had to wait, wanted to get it over with**, discusses the agonizing wait while in the ED for test results, the OB/GYN consult, the ultrasound and waiting for answers. A participant shared: *"They came back and put the ultrasound equipment in, and I'm basically waiting to find out if my baby's alive or dead. And they...just he's...like I waited for like two hours before the OB/GYN [came] from upstairs. He refused to do the ultrasound until they came down, that he didn't want to have to redo it when he came back down. I felt like he was trying to help me, but it was frustrating because I just ready to get it over with."* The last category grouped under this theme was **frustrated and upset**. This describes the emotional turmoil and roller coaster ride while waiting for diagnosis: *"So it was just frustrating because it was like they was telling me the baby's okay, then it's not, then it's okay, then it's not. So it's like a rollercoaster ride."*

### 3.6. Theme 4: Finally knowing and moving on

Three categories clustered under the category of Finally Knowing and Moving on, where the woman eventually learned that she did have a pregnancy loss. **They couldn't find a fetus** reflects when the provider was performing an ultrasound, and the woman learned that she was no longer pregnant. One woman described her experience: *"He sat back and he said, 'I couldn't find the baby,' that's when it hit and it was like...this can't really be happening, like this can't really be happening."* The second category was described as **I just lost my baby**. The women learned they had a pregnancy loss and the baby was gone. Some women said that they "just knew it," while others described a "shocked" or numb feeling. A participant describes her response: *"I was so surprised, because it, I couldn't believe that it was actually happening. I mean, it started just that evening. I couldn't believe that in under 5 h I was...I lose my baby, just like that...I was so shocked. I thought maybe it was just a blood clot or something. Maybe it's not my baby, [pause] heartbreaking. It didn't even get a chance to live, just come out like that."* Finally, some participants discussed their mechanisms for dealing with the loss of her pregnancy, these were named **coping with the loss**. Some prayed and wrote poetry, while others tried not to think about the pregnancy loss: *"I just broke down. It's like I was...I'm a Christian...It was just hard to believe that after I...because I prayed for my baby and I wanted it. It was just hard to believe that it was gone. I just try not to think about it now uh...I don't know, I write poetry so...I just took my baby's ultrasound in my wallet and put it in a book so I can write a poem and just leave it all there. It's not for me to understand, I just gotta deal with it."*

### 3.7. Theme 5: Assisting with the grieving process

Three categories were determined to be related to patient and provider interaction, including ways to assist the woman in her grief. The category **don't worry** reflects when the women were told to subside their fears, and they often felt brushed off or invalidated by these caregivers. One woman described her confusion: *"I told him that my doctor said my levels were low and he was like well we tested your levels and everything looks fine. So had me believing that my doctor was wrong and that maybe I was okay."* **Comforting me** refers to when the caregiver or other healthcare worker tried to alleviate the women's grief, this was primarily positive. One participant described an experience where *"the doctor sat down at the end of the bed and then she [the nurse] came over to the other side with the tissues, and just kinda like, I felt surrounded, I felt comfortable. Which was...it was still hard though. But they definitely helped...she had tissues, patting my tears away...it was so sweet. I wish I could remember her name."* The final category was called **don't blame yourself**. This is where someone told the participant it isn't her fault

and/or this happens all of the time: *"I was blaming myself. I said if I had come earlier maybe the baby would have been okay. So she said not, not to tell myself that, it was out of my control. You know first trimester pregnancies, you know when they terminate, it is out of the patient's control. And I shouldn't blame myself. It's nothing I could do...could have dealt with."*

## 4. Discussion

Many early pregnancy losses are managed in the ED; however, emergency care providers are often unfamiliar and feel unprepared for bereavement support [26]. There is a lack of evidence surrounding the psychological and emotional support of women diagnosed with a pregnancy loss in the ED [14]. Additionally, the environment of the ED is not sympathetic to the needs of women grieving the loss, or impending loss, of a pregnancy. Care is often rushed and interrupted, and frequently women are not given the option to view the lost fetus [27]. For healthcare providers in the ED, the psychosocial needs of the hemodynamically stable woman experiencing a pregnancy loss are often overlooked.

In this study, participants described their perceptions of clinical care. While providers are not able to predict or prevent the symptoms of pregnancy loss, these findings describe a lack of knowledge surrounding the symptoms of pregnancy loss. Women described uncertainty related to their symptoms and six of the eight women stated that they visited the ED more than once for their symptoms. There were several implications for improvement of ED care. One environmental concern of the participants was related to privacy, both within the room and when using the restroom. Women described using the public restroom and fears of losing the baby in the toilet as well as crying in front of other patients, and this is reflected in the literature [28,29]. Although a private restroom may not be available, a bedside commode may reduce anxiety. While some aspects of waiting and not knowing the outcome of the pregnancy is unavoidable, the participants described feelings of being excluded from pertinent information. Several women described feelings that the healthcare workers knew they were having a pregnancy loss and didn't tell them, or that information was withheld during the course of their ED stay. Keeping patients informed through hourly rounding and describing plan of care may alleviate these concerns.

The women in this study made statements related to their perception of clinical care in the ED. These were that they felt that the healthcare providers "didn't get it" and it was "like nobody had any sympathy." This is reflected in the literature where healthcare workers have been criticized for lack of compassionate care for women with a pregnancy loss [15–18]. While it is difficult to understand without a personal experience of a loss, additional evidence-based bereavement training in the ED may overcome this obstacle.

Our findings support previous literature and theories stating that healthcare providers have an influence on women with pregnancy loss and their perceptions of healthcare [10,13]. This study leaves implications for ED providers as many of the significant negative experiences can be mediated by individuals aware of women's needs during this life-changing event. Future intervention and education may provide the resources to healthcare providers thus creating a positive impact on the experience women have when seeking care for a pregnancy loss. Several recommendations for practice have been developed from the themes as described by participants.

## 5. Recommendations

### 5.1. Additional education

Providing education relating to concerning symptoms, discharge instructions, and when to seek care may reduce unnecessary ED visits. Providers should be aware of the need for thorough discharge instructions, including what to expect (i.e. amount of bleeding, passage of fetal

tissue), what concerns and when to seek care, as well as depression symptoms and emotional care resources. EDs can provide resource packets to patients including 24-hour hotlines for psychiatric symptoms, as women described feelings of shock and not fully comprehending instructions from the providers.

### 5.2. Environment

Many EDs do not have the physical capability of providing a private restroom; however, it is advised to choose a room closest to the bathroom for women experiencing pain or bleeding in pregnancy and/or provide a bedside commode. Finally, anticipating the physical needs of women with bleeding such as sanitary napkins and absorbent cloths can reduce embarrassment due to requests for these items.

### 5.3. Plan of care

Some providers may try to not frighten patients or be blamed for a potential diagnosis [30]; however, women experiencing symptoms of pregnancy loss are already concerned with the potential loss of their baby. Thus, keeping women and their families included in the clinical course and decisions will alleviate these concerns.

### 5.4. Bereavement training

Incorporating a bereavement training into continuing education or staff meetings is possible; however, optimally it would be initiated in the ED nurse orientation in a structured platform such as computer-based education modules or an in-service with social work upon hire. This bereavement training does not need to be limited to pregnancy loss, this training could be applicable to all ED healthcare workers supporting those persons coping with death and loss.

## 6. Limitations

Although the sample size was small ( $n = 8$ ), it was diverse in their backgrounds and data saturation was achieved. All of the participants spoke English and were from the Midwestern United States. Three women scored 13 or greater on the depression scale and were excluded, so their necessary exclusion may have impacted some of the results, as we do not know the experience of the women who are at a greater risk of depression; this reflects previous research findings that 39% of women met the criteria for either moderate or severe Posttraumatic Stress Disorder at three months after the pregnancy loss [31]. Additional research and specifically tailored interventions for participants at a greater risk of depression are needed. Another limitation was that the qualitative data were limited to the personal accounts of the women's experiences and were not correlated to the healthcare provider's interpretation nor the medical record of what occurred during the ED encounter.

## 7. Conclusion

Threats to pregnancy such as vaginal bleeding and abdominal pain are common [2,5–7], and many women will decide to seek ED care for their symptoms [32]. From the results of this study, women perceive that healthcare workers are withholding information and that the providers do not understand their experience. Additionally, the participants described methods of assisting with the grieving process that were beneficial, as well as some that were disconcerting. The findings of this study and recommendations described can serve as a foundation to further investigate the phenomenon and develop interventions to improve future ED care and positively impact the women's recovery and transition to normalcy.

## Appendix A

### A: Interview question guide

1. Tell me about your decision to go to the Emergency Department for this visit.
2. Tell me about what happened leading up to coming to the ED.
3. What kind of symptoms did you have?
4. What was your experience when you arrived to the Emergency Department?
5. What was it like waiting to be seen?
6. Tell me about your nurse.
7. Tell me about his/her attitude and care provided in the ED. Tell me about his/her caring behaviors.
8. Tell me about your physician/ mid-level provider. What was he/she like? Tell me about his/her attitude and care provided in the ED. Tell me about his/her caring behaviors.
9. Tell me about anyone else who cared for you in the ED.
10. Did you speak with a social worker during your ED visit? If so, tell me about that.
11. What kind of tests did you have in the emergency department?
12. Tell me about the experience of having a pelvic exam in the ED, if you had one.
13. Tell me about the environment of the emergency department.
14. What were you thinking about before you received your diagnosis while waiting in the Emergency Department?
15. Did your doctor/ mid-level provider explain your diagnosis? What words did he or she use?
16. How did you feel after your doctor told you about this?
17. Tell me about your discharge instructions.

## Appendix B. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ienj.2018.10.002>.

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