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Good practices in perinatal bereavement care in public maternity hospitals in Southern Spain

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ABSTRACT

Objective: To assess the attitudes and care practices of midwives and nurses in the province of Granada in relation to death care and perinatal bereavement, to determine their degree of adaptation to international standards and to identify possible differences in personal factors among those who best adapt to international recommendations.

Design: A local survey of 117 nurses and midwives from the five maternity hospitals in the province was conducted using the Lucina questionnaire developed to explore professionals' emotions, opinions, and knowledge during perinatal bereavement care. Adaptation of practices to international recommendations was assessed using the CiaoLapo Stillbirth Support (CLASS) checklist. Socio-demographic data were collected to establish their association with increased compliance with recommendations.

Findings: The response rate was 75.4%, the majority were women (88.9%), with a mean age of 40.9 (SD=1.4) and 17.4 (SD= 10.58) years of work experience. Midwives were the most represented (67.5%) and reported having attended more cases of perinatal death ($p = 0.010$) and having more specific training ($p<0.001$.) Of these, 57.3% would recommend immediate delivery, 26.5% would recommend the use of pharmacological sedation during delivery and 47% would take the baby immediately if the parents expressed their wish not to watch them. On the other hand, only 58% would be in favour of taking photos for the creation of memories, 47% would bathe and dress the baby in all cases, and 33.3% would allow the company of other family members. The percentage that matched each recommendation on memory-making was 58%, 41.9% matched the recommendations on respect for the baby and parents, and 23% and 10.3% matched the appropriate delivery and follow-up options, respectively. The factors associated with 100% of the recommendations, according to the care sector, were being a woman, a midwife, having specific training and having personally experienced the situation.

Key conclusions: Although the levels of adaptation observed are more favourable than in other nearby contexts, serious deficiencies are identified in the province of Granada with respect to internationally agreed recommendations on perinatal bereavement care. More training and awareness-raising of midwives and nurses is needed, which also considers factors related to better compliance.

Implication for practice: This is the first study to quantify the degree of adaptation to international recommendations in Spain reported by midwives and nurses, as well as the individual factors associated with a higher level of compliance. Areas for improvement and explanatory variables of adaptation are identified, which allow support for possible training and awareness-raising programmes aimed at improving the quality of care provided to bereaved families.

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Introduction

Stillbirth is a traumatic event that can drastically change the lives of parents and families (Heazell et al., 2016; Nuzum et al., 2018; Cacciatore et al., 2019; Fernández-Sola et al., 2020; Abiola et al., 2022). More specifically, it is described as the unintended loss of pregnancy through miscarriage (less than 24 weeks gestation), foetal death (more than 24 weeks gestation) or neonatal death (death of the baby in the first 28 days of life) (Sheresti et al., 2016; Kelly et al., 2021). The period following the loss of a stillborn baby has far-reaching consequences, mainly due to the negative effects of grief, anxiety, fear and suffering experienced by some bereaved parents, described as perinatal bereavement (Burden et al., 2016; Al-Maharma et al., 2016; Gold et al., 2016; Sheresti et al., 2016; Siadatnezhad et al., 2018).

In relation to its dimension, every year there are 2.6 million cases of foetal death worldwide, 3.0 million cases of neonatal death and about 1/4–5 pregnancies end in miscarriage (Lawn et al., 2016; World Health Organization, 2022). In addition, some women have high obstetric risks, which further increases their levels of anxiety and emotional distress, also in subsequent pregnancies (Gunnarsdottir et al., 2014; Sundermann et al., 2017; Fernández-Sola et al., 2020). This is why perinatal bereavement is considered a global health problem (De Bernis et al., 2016; World Health Organization, 2022).

Background

Appropriate management of perinatal death and bereavement encompasses comprehensive care focused on parents, but also on family members and society at large, as well as health professionals. For this reason, The Lancet published a series of articles in 2016 calling on the international community to do more to address the disparity in perinatal mortality rates between and within countries. They also called for an end to preventable stillbirths, calling for a "global consensus on an approach to care after death in pregnancy or childbirth for affected parents and their families, communities and caregivers in all settings" (De Bernis et al., 2016). In response to this demand, countries such as Ireland (NSBCPLPD, 2016), the United Kingdom (NBCP, 2018) or Australia (PSANZ, 2019) have established national standards on perinatal bereavement care in recent years.

These recommendations share some key points about the care provided to women and families experiencing a perinatal death. They recommend that: health professionals use simple language, show a non-judgemental sense of care and personal involvement; allow parents to spend as much time as they need with their baby; facilitate the creation of memories; provide information regarding the post-mortem examination; take time to discuss with parents; respect their cultural and religious backgrounds; and organise follow-up meetings to discuss the results of the examination and address unanswered questions during the early stages, or during hospitalisation (NSBCPLPD, 2016; NBCP, 2018; PSANZ, 2019).

In addition, eight basic and feasible evidence-based principles for bereavement care after stillbirth have been agreed upon. Although this expert group identified comparable findings globally, some indicators were very different between high-income and low-income countries. For example, in low-income countries, priority is given to respectful maternal care and counselling about future pregnancies, including family planning. In higher-income countries, it is essential that parents receive clear and easy-to-understand information about the options available for managing miscarriage or childbirth, as well as adequate information prior to hospital discharge, including contact with a referral professional during the follow-up period (Shakespeare et al., 2020).

However, the available evidence on practices associated with perinatal death and bereavement care is limited in most settings, especially in low- and middle-income settings, where the burden is greatest (Lawn et al., 2016; WHO, 2018; Horey et al., 2021).

Despite all this, many authors agree that, in general, the care received by parents and relatives after perinatal death does not meet their needs (Ellis et al., 2016; Siassakos et al., 2018; Shakespeare et al., 2019; Helps et al., 2020; Atkins et al., 2022), especially in Latin America and southern Europe, such as Spain (Horey et al., 2021). Thus, scientific evidence identifies different factors involved, and in turn interrelated, that influence the quality of perinatal bereavement care: some are related to the woman and the family (shock, pain, shame, guilt, anger, ignorance, stigma, isolation, culture) (O'Connell et al., 2016; Marwah et al., 2019; Martínez-Soriano et al., 2019; Pollock et al., 2020; Westby et al., 2021) others are external or due to social and/or health system organisation (legislation, local culture, family and social support, health personnel, time, physical space, hospital infrastructure and policies, coordination between health care departments) (Kelley and Trinidad, 2012; Lee, 2012; Beaudoin et al., 2018; (Shakespeare et al., 2020); (Fernández-Basanta et al., 2020)), and others are internal or personal to healthcare professionals (attitude to bereavement, grief, fear, insecurity, sadness, frustration, anxiety, helplessness, fatigue, training, confidence, communication skills) (Hutti et al., 2015; Steen et al., 2015; Kalu et al., 2018; Martinez-Soriano et al., 2018; Gandino et al., 2019; Pollock et al., 2021; Arach et al., 2022). In addition, the quality of the relationship established between professionals and parents (Beaudoin et al., 2018; Siassakos et al., 2018) and less explored individual factors of health professionals with epidemiological relevance, such as gender, age, years of work experience, number of cases attended or personal experience, may influence their attitudes and behaviours (Ben-Ezra et al., 2014; Gandino et al., 2014; (Fernández-Basanta et al., 2020)).

In Spain, perinatal death data have gradually decreased since 1975, and are now below the European average (Euro-Peristat Project, 2018). The province of Granada, southern Spain, with more than 230,000 inhabitants and around 7000 births per year, has presented a perinatal mortality rate above the national average consistently over the years, so that the last published perinatal mortality rate in 2021 was 3.89 in Spain and 4.37 in Granada (National Institute of Statistics, 2022), which reveals a greater impact of this phenomenon and the need for research focused on closing the gap. Although health care is universal and free, and almost all maternity hospitals have recommendations on death care and perinatal bereavement, no interventions have been reported in them, nor has their level of adaptation to international recommendations been evaluated.

Study objectives

The objectives of this study are to assess the attitudes and care practices of midwives and nurses in the province of Granada in relation to death care and perinatal bereavement, to determine their degree of adaptation to international standards and to identify possible differences in personal factors among those who best adapt to international recommendations.

Methods

This is a multicentre, cross-sectional study carried out in five maternity hospitals in the province of Granada (two of them urban and three rural), which provide services within the Andalusian Public Health System, with no exclusion criteria. The sample

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included all university and non-university primary, secondary and tertiary level hospitals in the province of Granada. Primary level hospitals are those with few specialities, with a capacity of less than 200 beds, and are referred to as county or first level referral hospitals. Second-level hospitals are defined as hospitals with five to ten clinical specialities, a bed capacity of between 200 and 800 beds, and are called provincial hospitals. Tertiary level hospitals are defined as highly specialised hospitals with specialised diagnostic imaging units, a bed capacity of between 300 and 1500 beds and are called central, regional, or tertiary level hospitals. A University hospital is a hospital in which teaching activities are carried out.

Participants

Midwives and nurses working in obstetric, surgical or emergency departments were selected as the professionals of reference for parents (Steen et al., 2015; Ellis et al., 2016; Meaney et al., 2017; Kalu et al., 2020; Qian et al., 2021; Fernández-Basanta et al., 2020). The negative impact on the emotional trauma of bereaved parents depends, to a large extent, on their ability to provide adequate bereavement care (Aileen and Trish, 2014; Meredith et al., 2017). Moreover, they constitute homogeneous groups to be analysed (Ellis et al., 2016; Gandino et al., 2019; Fernández-Basanta et al., 2020) and to evaluate most of the recommended interventions.

Data collection

Between November 2020 and May 2021, all participants were informed of the aims of the study and their informed consent was sought, ensuring voluntariness and confidentiality of the data with the help of the heads of the maternity departments.

The Lucina questionnaire developed by the charity CiaoLapo to provide support to families facing perinatal loss was used. This questionnaire consists of 23 questions with 3 response options (Yes; No; Don't know) and explores the emotions, beliefs and knowledge of professionals focused on the care of women experiencing stillbirth and perinatal loss. It also assesses the compliance of practices with international recommendations, through questions selected from the CiaoLapo Stillbirth Support (CLASS) checklist also designed by that organisation and published in a previous document (Ravaldi et al., 2018). This checklist is a summary of the best evidence from international guidelines documented in the Irish health system (NSBCPLPD, 2016); indicated by the Perinatal Society of Australia and New Zealand (PSANZ, 2019); integrated with those of the Canadian Paediatric Society (van Aerde et al., 2001), and following UNICEF-WHO-UNFPA guidelines (UNICEF-WHO-UNFPA, 2017). It also includes the steps outlined in the eight final principles recently agreed globally by international perinatal bereavement experts (Shakespeare et al., 2020)).

The original questionnaire, published in English by its authors (Ravaldi et al., 2018), was translated into Spanish by two professional translators specialised in health issues, one of them a native Spanish speaker and the other a native English speaker, following a validated procedure. Subsequently, four researchers specialised in perinatal bereavement reviewed the translation and assessed the cultural adaptation of each item to determine the content validity of the questionnaire in the Spanish context, making minor adjustments to the items in the four sections and to some items based on the literature. The final questionnaire was divided into two sections with a total of 17 questions (Appendix 1).

The variables analysed in the study were:

I) **Participant's profile**: gender, age, professional category, years of work as midwife and/or nurse, and level of education (5 questions).

II) **Background**: at least 2 h of specialised training in perinatal bereavement, number of perinatal death cases attended and personal experience of perinatal death (3 questions).

III) **Compliance: practices related to the following areas are explored:**
- Respect: respectful attitudes towards stillborn babies and their parents. The most important items evaluated are naming the baby; bathing and dressing the baby; providing privacy enabling partners to spend time together. Corresponding Lucina items: 9c, 9e, 11b, 12d, and 12i.
- Birth care: addressing possible delivery options. The most important points evaluated are supporting parents in making appropriate decisions about childbirth, offering the option of staying at home before delivery and offering obstetric analgesia to avoid sedation. The recent "Guía de Asistencia a la Muerte Perinatal" published by the Spanish Society of Gynaecology and Obstetrics specifically points out the avoidance of all drugs that may have a sedative effect, to avoid their influence on the patient's state of grief (SEGO, 2021). Corresponding articles by Lucina: 9f, 9g, 10b, 10c, 10e, 11a, 11c, 13a, 13b and 13e.
- Making memories: helping parents to create memories of their babies. The most important items assessed are taking photos of the baby as a keepsake; helping parents to see, wear, bathe and dress their babies; providing parents with mementos such as a lock of hair, hand and/or footprints, or identification bracelet. Corresponding Lucina items: 12a, 12f, 12g, 13f, 13g, 13h, 13i.
- Aftercare: providing adequate care and support immediately after delivery and beyond. The most important points assessed are informing mothers about the physical and psychological consequences of perinatal bereavement; providing early psychological support; offering written information about support services; discussing the implications for future pregnancies; and organising follow-up meetings. Corresponding Lucina topics: 13j, 13l, 13m, 14, 15 and 16a.

Ethical considerations

This study has been authorised by the participating healthcare centres and complies with good clinical practice guidelines, in accordance with European Directive 2001/20/EC and Law 14/2007, of 3 July, on biomedical research. The processing of personal data in health research is regulated by the provisions of Organic Law 3/2018, of 5 December, on the Protection of Personal Data and Guarantee of Digital Rights in Spain. The research protocol received a favourable resolution from the Research Ethics Committee of the province of Granada with code 0097-N-21.

Data analysis

The questionnaire data were analysed descriptively and the number of health professionals who adapted 80% and 100% correctly to all recommendations according to the four defined domains was analysed, as previously described by Ravaldi et al. (2018). Subsequently, a bivariate analysis was performed to explore the possible association between the personal factors of midwives and nurses and a higher degree of adaptation to the four defined domains through Fisher's exact test, setting the significance level at $p<0.05$. For this analysis, the quantitative variables (age, years of work and number of cases attended) were dichotomised considering the median value. Analyses were performed with the statistical programme SPSS vs. 25 (IBM, New York, NY, USA).

Table 1
Sociodemographic characteristics and background by professional category ($N = 117$).

	Midwives n (%) 79 (67.5)	Nurses n (%) 38 (32.5)	Total n (%) 117 (100)	*p* value
Age (years) (Mean (SD))	41.52 (12.24)	40.03 (9.78)	40.98 (11.47)	0.533
Work experience (years) (Mean (SD))	18.46 (11.36)	15.42 (9.55)	17.47 (10.86)	0.158
Gender				
Male	6 (7.6)	7 (18.4)	13 (11.1)	0.081
Female	73 (92.4)	31 (81.6)	104 (88.9)	
Studies achieved				
Postgraduate	32 (40.5)	17 (44.7)	49 (41.9)	0.664
Others	47 (59.5)	21 (55.3)	68 (58.1)	
Training in stillbirth				
Yes	68 (86.1)	19 (50)	87 (74.4)	<0.001
No	11 (13.9)	19 (50)	30 (25.6)	
Professional experience in stillbirth				
Yes	9 (11.4)	8 (21.1)	17 (14.5)	0.165
No	70 (88.6)	30 (78.9)	100 (85.5)	
Cases of stillbirth taken care of				
≤ 5	24 (30.8)	17 (44.7)	72 (61.5)	0.010
> 5	55 (69.6)	21 (55.3)	45 (38.5)	

Abbreviation: SD: Standard deviation.

Table 2
Attitudes of HCPs towards parents and stillborn babies.

How can HCPs help parents after a stillbirth	Yes n (%)	No n (%)	Do not know n (%)
Allowing the couple to stay together ($n = 111$)	110 (94)	0 (0)	1 (0.9)
Explaining all possible procedures ($n = 113$)	97 (82.9)	7 (6)	9 (7.7)
Providing one-to-one assistance ($n = 112$)	96 (57.3)	21 (17.9)	22 (18.8)
Delivering as soon as possible ($n = 110$)	67 (57.3)	21 (17.9)	22 (18.8)
Washing, dressing, and preparing the baby anyway ($n = 106$)	55 (47)	26 (22.2)	25 (21.4)
Immediately taking the baby away if parents do not want to see it ($n = 107$)	58 (49.6)	30 (25.6)	19(16.2)
Creating an intimate and comfortable environment ($n = 112$)	112 (95.7)	0 (0)	0 (0)
Providing accompaniment and support ($n = 111$)	108 (92.3)	1 (0.9)	3 (2.6)
Providing information on what is happening ($n = 112$)	106 (90.6)	4 (3.4)	2 (1.7)
Listening empathetically ($n = 113$)	111 (94.9)	2 (1.7)	0 (0)
Involving them in decision making ($n = 109$)	98 (83.8)	4 (3.4)	7 (6)
Presence of the partner ($n = 112$)	108 (92.3)	1 (0.9)	3 (2.6)
Presence of relatives ($n = 111$)	39 (33.3)	25 (21.4)	47 (40.2)

Abbreviation: HCPs: health care providers.

Results

A total of 155 questionnaires were distributed to midwives and nurses, of which 117 were completed, giving a response rate of 75.48%. Of these, 88.9% were women and the mean age was 40.9 years (SD=11.4). Midwives were the most represented (67.5%) and, on average, midwives reported 17.4 (SD=10.8) years of work experience; 58% had no postgraduate education, although one in four (74%) had received at least 2 h of specialised training on perinatal bereavement; 61% reported having cared for five or fewer women in perinatal death, and 15% had experienced perinatal death on a personal level. Compared to nurses, midwives reported having received more training on the subject ($p<0.001$) and having cared for more cases ($p = 0.010$) (Table 1).

Table 2 shows the attitudes of midwives and nurses towards perinatal death. Almost all participants stated that they can help families by providing an intimate and comfortable environment (95.7%), listening with empathy (94.9%) and allowing the couple to stay together (94%). On the other hand, almost half of the sample is of the opinion that the baby should be taken away immediately if the parents say so (49.6%), 47% say that the baby should be bathed and dressed in all cases, and 33% would allow other family members to be present.

The perinatal bereavement practices and strategies considered most appropriate by midwives and nurses are shown in Table 3. Regarding childbirth, between 8% and 26% of the participants were not clear about the best options: 81% stated that the most indicated type is vaginal delivery and 3.4% opted for caesarean section; 70% felt that the use of obstetric analgesia is good practice and one third (26.5%) chose pharmacological sedation. In terms of strategies to help families, the majority thought it was important to support mothers during labour and delivery (93.2%) and to allow the baby to stay with the parents for as long as they saw fit (89.7%). Taking photos of the baby as a keepsake was approved by 58% of the sample. As useful measures for the parents during the postpartum period, the most important for the health professionals was to arrange a follow-up meeting (91.5%), as well as offering them resources to manage their own grief (84.6%). On the other hand, 10.3% thought that discussing a future pregnancy as early as possible would be helpful.

Table 4 shows the number of midwives and nurses surveyed who conformed 100%, 80% or less to the recommendations according to the international guidelines in the four selected areas of the CLASS checklist: respect, delivery, recall and aftercare. Between 30% and 46% of midwives and nurses were not 80% compliant, and only between 10% and 58% were 100% compliant, depending on the area analysed. A larger gap between international recommendations and actual practice is observed in relation to delivery options (10.3%) and follow-up (23.9%).

Table 3
Practices and strategies of HCPs when dealing with stillbirth.

Which is the most suitable type of delivery in case of stillbirth?			
	Yes n (%)	No n (%)	Do not know n (%)
Vaginal delivery (n = 107)	95 (81.2)	2 (1.7)	10 (8.5)
Induced labour (n = 106)	68 (58.1)	7 (6)	31 (26.5)
Caesarean section (n = 99)	4 (3.4)	79 (67.5)	16 (13.7)
Use of analgesia during labour (n = 108)	82 (70.1)	3 (2.6)	23 (19.7)
Use of sedatives during labour (n = 101)	31 (26.5)	43 (36.8)	27 (23.1)
What are the best strategies to help parents cope with grief and loss?			
	Yes n (%)	No n (%)	Do not know n (%)
Supporting mothers during labour/delivery (n = 112)	109 (93.2)	3 (2.6)	0 (0)
Shortening the length of stay (n = 107)	87 (74.4)	10 (8.5)	10 (8.5)
Let the couple with the baby for as long as they need (n = 113)	105 (89.7)	4 (3.4)	4 (3.4)
Taking pictures of the babies as mementos (n = 118)	68 (58.1)	13 (11.1)	27 (23.1)
What are the best ways that HCPs can offer adequate support to the family in the post-partum?			
	Yes n (%)	No n (%)	Do not know n (%)
Refer to psychology/mental health (n = 108)	71 (60.7)	11 (9.4)	26 (22.2)
Provide a follow-up appointment to parents (n = 114)	107 (91.5)	1 (0.9)	6 (5.1)
Offer resources for self-management of grief (n = 108)	99 (84.6)	3 (2.6)	6 (5.1)
Suggest a self-help group (n = 112)	67 (57.3)	43 (36.8)	2 (1.7)
Recommend a new pregnancy as soon as possible (n = 114)	12 (10.3)	52 (44.4)	50 (42.7)

Abbreviation: HCPs: health care providers.

Table 4
Number of perinatal HCPs complying with the International Guidelines in each section (N = 117).

	HCP aware of guidelines recommendation n (%)		
	Less than 80%	Aware of at least 80%	Aware of all items
Respect for baby and parents	36 (30.76)	32 (27.4)	49 (41.9)
Birth options	38 (32.47)	67 (57.3)	12 (10.3)
Creating memories	31 (26.49)	18 (15.4)	68 (58.1)
Aftercare	54 (46.15)	35 (29.9)	28 (23.9)

Abbreviation: HCPs: health care providers.

Table 5 shows the associations between socio-demographic variables and professional background, showing 100% compliance with the recommendations in the four sections. Respect was associated with professional category (p<0.001), having received at least 2 h of specialised training in perinatal bereavement (p = 0.005), and own experience (p = 0.034); memory making was associated with gender (p = 0.041), professional category, perinatal bereavement training (p<0.001), and own experience (p<0.001); and finally, follow-up was associated with gender (p = 0.036) and professional category (p<0.001).

Discussion

To our knowledge, this is the first study in Spain to assess the adaptation of attitudes and behaviours of midwives and nurses in public maternity wards to the currently agreed international recommendations on perinatal bereavement care. We have had access to primary sources, and identified individual factors related to a higher degree of compliance, thus providing evidence in an almost unexplored area (Ravaldi et al., 2018).

We received more responses from women, reflecting the general gender distribution within these professional categories, with midwives being the most represented health professionals, as in other studies on perinatal bereavement care (Fenwick et al., 2007; Wallbank and Robertson, 2013; Ravaldi et al., 2018; Brierley-Jones et al., 2018). Within the Spanish healthcare system, it is midwives who attend to bereavement from 28 weeks' gestation and care in the delivery rooms of selected centres, where perinatal death is most tangible and painful (Hernández-Garre et al., 2017; Martínez-Soriano et al., 2018). In fact, they are the ones who have attended the most cases and have received the most training on bereavement, so they may be more willing to participate in this type of study.

Regarding the beliefs and behaviours of the health professionals surveyed on what can be useful and help parents in such a situation and the evidence-based recommendations, we found a certain mismatch between many of them. Among the most widespread opinions far from the recommendations were to terminate the pregnancy as soon as possible (57%), to take the baby away immediately if the parents do not want to see it (49.6%), to use pharmacological sedation during delivery (26.5%) and to recommend a future pregnancy as soon as possible (10.3%). Other recommended practices followed by a limited number of health professionals were to take photos as a keepsake (58.1%), to bathe and dress the baby in all cases (47%) and to allow other family members to be present (33.3%). Our findings are therefore consistent with the literature that states that in Western industrialised countries, the care provided to families, both immediately after birth and in the days and months that follow, is weak and often inadequate (Steen et al., 2015; Burden et al., 2016; Ravaldi et al., 2018; Cassidy, 2022). In this regard, it should be added that in European countries such as the UK, 25% of parents report that health professionals repeatedly fail to provide high quality perinatal bereavement care (NBCP, 2020). In Italy, a survey of health

Table 5
Factors associated with 100% of recommendations in each section.

	Respect 100%			Birth 100%			Mementos 100%			Follow-up 100%		
	Yes n (%)	No n (%)	*p value*	Yes n (%)	No n (%)	*p value*	Yes n (%)	No n (%)	*p value*	Yes n (%)	No n (%)	*p value*
Gender												
Male	2 (4.1)	11 (16.2)	0.070	1 (8.3)	12 (11.4)	1.000	4 (5.9)	9 (18.4)	0.041	0 (0)	13 (14.6)	0.036
Female	47 (95.9)	57 (83.8)		11 (91.7)	93 (88.6)		64 (94.1)	40 (81.6)		28 (100)	76 (85.4)	
Age												
≤ 40	26 (53.1)	34 (50)	0.852	5 (41.7)	55 (52.4)	0.552	39 (57.4)	21 (42.9)	0.137	19 (67.9)	41 (46.1)	0.053
>40	23 (46.9)	34 (50)		7 (58.3)	50 (47.6)		29 (42.9)	28 (57.1)		9 (32.1)	48 (53.9)	
Professional Category												
Nurse	7 (14.3)	31 (45.6)	<0.001	2 (16.7)	36 (34.3)	0.332	12 (17.6)	26 (53.1)	<0.001	2 (7.1)	36 (40.4)	0.001
Midwife	42 (85.7)	37 (54.4)		10 (83.3)	69 (65.7)		56 (82.4)	23 (46.9)		26 (92.9)	53 (59.6)	
Training on PB												
Yes	43 (7.8)	44 (64.7)	0.005	11 (91.7)	76 (72.4)	0.292	60 (88.2)	27 (55.1)	<0.001	24 (85.7)	63 (70.8)	0.141
No	6 (12.2)	24 (35.3)		1 (8.3)	29 (27.6)		8 (11.8)	22 (44.9)		4 (14.3)	26 (29.2)	
Cases taken care of												
≤ 5	18 (36.7)	27 (39.7)	0.848	2 (16.7)	43 (41)	0.126	25 (36.8)	20 (40.8)	0.703	11 (39.3)	34 (38.2)	1.000
>5	31 (63.3)	41 (60.3)		10 (83.3)	62 (59)		43 (63.2)	29 (59.2)		17 (60.7)	55 (61.8)	
Time worked												
≤16	25 (51)	36 (52.9)	0.853	6 (50)	55 (52.4)	1.000	38 (55.9)	23 (46.9)	0.355	18 (64.3)	43 (48.3)	0.193
>16	24 (49)	32 (47.1)		6 (50)	50 (47.6)		30 (44.1)	26 (53.1)		10 (35.7)	46 (51.7)	
PB own experience												
Yes	3 (6.1)	14 (20.6)	0.034	0 (0)	17 (16.2)	0.210	3 (4.4)	14 (28.6)	<0.001	4 (14.3)	13 (14.6)	1.000
No	46 (93.9)	54 (79.4)		12 (100)	88 (83.8)		65 (95.6)	35 (71.4)		24 (85.7)	76 (85.4)	

Abbreviation: PB: Perinatal bereavement.

professionals found significant differences between the standards of care defined by international guidelines and current practice in Italy (Ravaldi et al., 2018). Similarly, in Spain, Cassidy et al., in their large survey study of 796 women who had experienced stillbirth, concluded that many standard care practices in other high-income countries are not routinely carried out in Spanish hospitals (Cassidy, 2018). Therefore, although there is support for an individualised and flexible approach, considering the individual and cultural response of parents to death (Cacciatore et al., 2010; Bakhbakhi et al., 2017), the absence of established guidelines for perinatal bereavement care leads to great variability of intervention by HCP (Fernández-Alcántara et al., 2020). It is also noted that such practices are often based on intuition and personal beliefs, rather than on better evidence (Steen et al., 2015; Martínez-Soriano et al., 2018; (Fernández-Basanta et al., 2020); Cassidy et al., 2022). In this regard, Zhuang et al., in their recent review of Clinical Practice Guidelines for perinatal bereavement care, conclude that if they are of good quality, they are useful instruments that can provide reliable evidence to increase the capacity of healthcare professionals, standardise the management of perinatal death and improve clinical practice outcomes (Zhuang et al., 2022).

However, when assessing the degree of compliance with international recommendations, we can observe that our results are significantly more favourable than those reported by Ravaldi et al. in Italy, whose method we have reproduced (Ravaldi et al., 2018). Although the percentage of professionals in our study who received specialised training in perinatal bereavement and who had attended five cases or less is shown to be higher than those reported by Ravaldi et al. (2018), the main differences could be due to the limitation of professional category (midwives and nurses) and the timing (6–11 years apart). The literature often states that nurses' and midwives' practices are more empathetic and humane towards the emotional experience of loss, compared to physicians, with whom they may even differ in terms of what is appropriate care (Fenwick et al., 2007; Gold et al., 2007) ; O'Connell et al., 2016; Aiyelaagbe et al., 2017; Beaudoin et al., 2018; Cassidy, 2022). On the other hand, in the last decade in Spain there has been an increased professional awareness of the suffering of bereaved parents (Hernández-Garre et al., 2017; Cassidy, 2018; SEGO, 2021), a trend that can be reflected in this study.

Attitudes and practices related to the areas of delivery and follow-up were the most misaligned with international recommendations, perhaps the most clinical and technical areas of care. Thus, we agree with other authors that some of the more specific aspects of the management of perinatal death appear to have been neglected by health professionals (Steen et al., 2015; Ravaldi et al., 2018; Fernández-Alcántara et al., 2020). However, such a finding disagrees with studies reporting how caregivers tend to feel more confident with biological care, the treatment of the physical aspects so common in these situations, versus psychological or psychosocial care (Ellis et al., 2016; Hernández-Garre et al., 2017; Martínez-Soriano, et al., 2018; Fernández-Alcántara et al., 2020; (Fernández-Basanta et al., 2020)).

Regarding variables related to higher compliance, we observed that midwives were more compliant with the norms in terms of respect, memory building and follow-up, three of the four areas analysed. In Spain, midwives, and nurses, compared to doctors, often have subordinate positions associated with traditional caring and supportive roles (Cassidy, 2022), and nurses may believe that certain interventions in dealing with perinatal death and bereavement are not part of their responsibility (Steen et al., 2015), which requires further research. On the other hand, it is striking that midwives do not show a higher level of compliance in the field of childbirth, both because of their specialisation and because they have functions related to this task in the Spanish health system. These results reaffirm the need for continued and updated training on best practices for dealing with perinatal bereavement amongst the midwives and nurses involved, as is strongly stated in the literature (De Bernis et al., 2016; Bakhabakhi et al., 2017; Gandino et al., 2019; Fernández-Alcántara et al., 2020; Aggaral and Moati, 2022; Atkins et al., 2022).

Having received at least 2 h of specialised training in perinatal bereavement and having personally experienced such a situation were associated with a better adaptation to respect and the

creation of spaces of remembrance. Meaningful learning, or learning through experience, seems to make it easier for professionals to acquire the appropriate skills to deal with such a complex situation, mainly for the self-management of feelings that, to a large extent, determine their attitudes and behaviours in the more emotional or psychological areas of care (Nuzum et al., 2014; Heazell et al., 2016; Hernández- Garre et al., 2017; Martínez-Soriano et al., 2018). Indeed, professional training based exclusively on academic knowledge has proven to be rather ineffective in addressing the emotional needs of bereaved parents (Siassakos et al., 2018; Gondino et al., 2019), the most appreciated (Peters et al., 2016; Nuzum et al., 2018; Redshaw et al., 2021; Horey et al., 2021; Cassidy, 2022). However, it could be argued that having experienced foetal loss themselves as healthcare professionals does not guarantee that these professionals are or have been more sensitive to parents' wishes or needs, nor that they are or have been more adherent to guidelines. This is therefore an area for further research.

Being a woman was associated with 100% compliance with recommendations in the creation of reports and follow-up areas. Martínez-Soriano et al. found no gender differences among midwives in terms of awareness of perinatal death (Martínez-Soriano et al., 2018), but they seem to exist in their behaviour. In fact, there is evidence documenting strong interactions of this variable with a wide range of interventions carried out by health professionals during their clinical practice (Eggermont et al., 2018; Neugut et al., 2019). Therefore, we suggest the incorporation of a gender perspective as a future line of research on perinatal death and bereavement.

Finally, it should be noted that the findings of this study not only call for training and research to improve the training and support of health professionals dealing with these losses, but also for best evidence-based, culturally specific, and context-specific care guidelines or Clinical Practice Guidelines, as recommended globally (Flenady and Boyle, 2020; Zhuang et al., 2022). Furthermore, our perinatal mortality rates, above the national average, would call for frequent identification of variability and adaptation of health practices following death, but it should be essential to do so during pregnancy, to try to prevent it, through local audits and specific care programmes (Norris et al., 2017; Widdows et al., 2018; Andrews et al., 2020).

Strengths and limitations

The cross-sectional design of the study has allowed a global approach to the current reality of nurses and midwives in the province of Granada who care for families going through perinatal bereavement. As this was an exploratory study, no power calculations were performed, although the univariate analysis allowed us to identify some individual factors of midwives and nurses related to greater compliance with international recommendations, which are consistent with the literature. The internal validity of the study could be considered adequate, based on its good acceptance among the professionals involved (response rate of 75.48%), and even the external validity, to infer the results of the public maternity hospitals in the province, as all of them are involved. Moreover, these results can be extrapolated to other similar provinces, since we have included university and non-university hospitals at primary, secondary and tertiary levels. In fact, primary level hospitals (less than 200 beds) are the most common in Spain and are usually underrepresented in this type of studies (Camacho-Ávila et al., 2020; Christou et al., 2021; Munin et al., 2021; Power et al., 2022). On the other hand, by accessing primary sources, made up of health professionals, and having guaranteed the voluntary nature and anonymity of the participants, any information bias was minimised. Although the questionnaire data have not been completed with a qualitative analysis, nor have they been compared with the clinical records or with the satisfaction of women and families attending these centres to observe their convergence, studies carried out previously in our setting reported the existence of such shortcomings (Steen et al., 2015; Hernández-Garre et al., 2017; Martínez-Soriano et al., 2018; Fernández-Alcántara et al., 2020; Camacho-Ávila et al., 2020).

Due to the selection of midwives and nurses sharing care tasks, the responses may be more homogeneous than those observed in other studies involving more professional categories (Ravaldi et al., 2018; Martínez-Soriano et al., 2018; Fernández-Alcántara et al., 2020). However, we are aware that they also have very different responsibilities depending on their work environment and the time of the process the family is going through (McCreight, 2005; Hutti et al., 2016). Furthermore, as this was not a representative sample of health professionals who have, or may have, contact with families during their experience of perinatal death in hospitals or primary care settings, including students and non-technical staff (Aggarwal and Moatti, 2022), we cannot extrapolate the results to other members of the care team. Evaluation of the adaptation of interventions to international recommendations in different settings, both by midwives and nurses independently and by other care providers, would help to expand our knowledge in this area.

Conclusion

The findings of this study point to certain deficiencies in the adequacy of midwifery and nursing interventions to international standards on death and perinatal bereavement care in the province of Granada and, consequently, areas for improvement. However, the levels of compliance observed are, in general, more favourable than those published in neighbouring geographical areas, and seem to confirm a certain transition towards care approaches more focused on the psychosocial aspects of care. Even so, given the current interest in measuring the quality of care, and considering the impact of perinatal mortality in our province, overcoming these shortcomings requires training and awareness-raising resources, the design of which could consider, among other factors, the professional category of the health professionals, gender, previous level of training and personal experience in perinatal bereavement.

Ethical approval

The realization of the study was authorized by all participating hospital authorities. All data were acquired and analysed anonymously. The research protocol received a favourable resolution from the Research Ethics Committee of the Granada province under code 0097-N-21.

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Declaration of Competing Interest

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.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2023.103749.

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