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“Stranger in a mask” midwives’ experiences of providing perinatal bereavement care to parents during the COVID-19 pandemic in Ireland: A qualitative descriptive study

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ABSTRACT

Objective: To explore the experiences and perceptions of midwives providing perinatal bereavement care during the COVID-19 pandemic and to identify the barriers and facilitators to providing compassionate bereavement care.

Design: A qualitative descriptive design was utilized to address the research question. Following ethical approval, in depth, semi structured interviews were undertaken to explore midwives’ experiences of providing care to parents following perinatal bereavement. Narrative data was analyzed using thematic analysis.

Setting: A standalone regional maternity hospital located in a large metropolitan center in the Republic of Ireland.

Participants: A purposeful sample of eleven midwives, who cared for bereaved parents during the COVID-19 pandemic volunteered to participate in the study.

Findings: Two main themes were identified, each with associated subthemes (1) Challenges of providing compassionate bereavement care during a pandemic (2) Psychological effect and coping strategies utilised by midwives during a pandemic.

Conclusion: The COVID-19 pandemic brought unprecedented challenges when providing perinatal bereavement care. The mandatory infection prevention and control measures significantly disrupted human communication and connections. Participants in the study utilized techniques to optimize care while adhering to COVID-19 guidelines, and simultaneously putting their own fear and anxieties aside.

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Introduction and background

Perinatal loss is a complex experience (Leitao et al., 2021), and is widely accepted as one of the most painful forms of bereavement. It can be sudden, unexpected, unexplained and may produce a greater emotional response than that of the death of someone who has lived a long life (Hughes and Goodall, 2013; Coffey, 2016; Quinn, 2016). Perinatal bereavement is the experience of parents that begins immediately following the death of an infant through miscarriage, stillbirth, neonatal death and elective termination of pregnancy for fetal anomaly (Fenstermacher and Hupcey, 2013). Worldwide, there are 2.64 million cases of stillbirths and three million cases of neonatal death annually (Lozano et al., 2011) with miscarriage accounting for one fifth of all pregnancies (O’Farrell et al., 2019). In Ireland, figures from the National Perina-

tal Epidemiology Centre (2019) reported 381 perinatal deaths including 235 stillbirths in 2017.

A parent’s grief journey is linked to the quality of care they receive (Burden et al., 2016; Quinn, 2016). Caring for parents inappropriately during this time can lead to devastating and long-lasting consequences that can severely affect a woman and her partners grieving journey (Burden et al., 2016; Quinn, 2016; Nuzum et al., 2017). Perinatal bereavement care encompasses physical, psychological, emotional and spiritual support provided by the multidisciplinary team to bereaved parents, their family, siblings and grandparents (Health Service Executive, 2016). Healthcare professionals who care for bereaved parents have a unique opportunity to guide and assist a woman and her family at this time. Midwives are acknowledged as key care providers for bereaved parents and may be the first, last and most frequent contact parents have with healthcare professionals (Wallbank and Robertson, 2013; Fernández-Basanta et al., 2021).

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The midwife's role in bereavement care is outlined in the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death published in 2016 in Ireland and is consistent with international best practice. This role involves providing effective, sensitive and compassionate communication and care to parents who experience a perinatal bereavement. Care includes consideration of parent's individual informational needs and involves preparing parents for the emotional and physical responses to their diagnosis and anticipatory care guidance (Health Service Executive, 2016). A sensitive discussion of parents preferences, fears, concerns, wishes and plans enables parents to make informed choices about their care (Quinn, 2016). Midwives support parents to create memories of their babies (photographs and footprints, making a memory box), arrange a service, burial or cremation for their baby and organize referral to the appropriate hospital and community specialist service providers and national and local support organizations (Health Service Executive, 2016). In addition, midwives support women to prepare for and give birth and provide postnatal care which includes managing lactation issues (Health Service Executive, 2016). The care a woman receives during this time is known to have a significant impact on her experience and long-term recovery (Ravaldi et al., 2018; Boyle et al., 2020). Midwives are provided with mandatory bereavement care training on commencement of employment and bereavement training refresher courses every three years to prepare them for this role (Health Service Executive, 2016).

It is acknowledged that the provision of perinatal bereavement support can be an emotional and traumatic time for health care professionals as well as parents (Jonas-Simpson et al., 2013; Mulvihill and Walsh, 2014; Health Service Executive, 2016; Nash et al., 2018). Delivering quality bereavement care to parents can cause stress and anxiety for health care professionals, especially if they feel poorly prepared for this role (Agwu Kalu et al., 2018; Laing et al., 2020). Therefore, providing quality bereavement care can be challenging in both complexity and sensitivity and is potentially heightened in the context of a pandemic, such as COVID-19.

In March 2020, the World Health Organisation declared COVID-19 a global pandemic (Arden and Chilcot, 2020). In response, the Irish government in line with international recommendations, implemented restrictions to curb the spread of COVID-19. The rapid and unexpected development of COVID-19 altered the way maternity services were delivered in response to the pandemic. The HSE applied mandatory directives in all hospitals which included: the wearing of personal protective equipment, visiting restrictions, social distancing, limiting interaction to under 15 min and partners only allowed to attend at the birth of the baby or on compassionate grounds.

The COVID-19 pandemic has created unique and unprecedented challenges to the grieving process for women experiencing a perinatal bereavement (Mayland et al., 2020). Women and their families experiencing bereavement during these times face particularly difficult circumstances. The grief experienced during COVID-19 can be heightened by lack of social support, loneliness and face to face mourning rituals (Carr et al., 2020). Factors that previously contributed to compassionate bereavement care, such as non-verbal communication were impacted by changes to infection prevention and control practices (IP&C). The COVID-19 pandemic has presented many difficulties to healthcare systems, and healthcare staff have had to swiftly adapt to changes imposed by the pandemic. In addition, maternity care providers are challenged to balance the needs and safety of pregnant women with their own safety (Pollock et al., 2020).

COVID 19 guidelines will be in place for the foreseeable future. Renfrew et al. (2020) suggests that the development of high quality COVID-relevant solution to optimize care, need to be co-

ated with staff. It is imperative that midwives are provided with support structures to assist them in providing quality bereavement care during unprecedented events, such as COVID-19. To do this we need to listen to midwives' voices and hear their perspectives on how best to organise services to keep women and their families safe and at the same time support them through their grief journey (Renfrew et al., 2020). Considering that midwives are the main care givers in providing bereavement care it is important that their voices be heard (Renfrew et al., 2020) as quality bereavement care supports the grief journey. Understanding midwives' experiences in providing bereavement support may inform education, change and quality improvement to perinatal bereavement care provision (Shorey and Chan, 2020). Therefore, this study explored the experiences of midwives during a public health crisis to gain a deeper and more holistic insight into their experiences of providing perinatal bereavement care, to enhance support for both the bereaved woman and the midwife providing care.

Methods

The aim of this research was to explore midwives' experiences and perceptions of providing care to bereaved parents during the COVID-19 pandemic and a qualitative descriptive research methodology was employed in this study. This research design seeks to discover, understand and describe an experience while staying close to participants accounts (Neergaard et al., 2009; Sandelowski, 2010; Kim et al., 2017). A qualitative descriptive research approach provides a flexible, straightforward description of experiences (Sandelowski, 2010) and is particularly suited to enable novice researchers to explore important healthcare questions that have the potential to contribute to change and quality improvement in the clinical setting (Bradshaw et al., 2017; Colorafi and Evans, 2016; Chafe, 2017; Doyle et al., 2020; Kim et al., 2017). The conduct and reporting of this study was in line with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007). A qualitative descriptive design was deemed the most appropriate approach to answer the research question: what are midwives' experiences of caring for bereaved parents during the COVID-19 pandemic?

Objective

- (1) To explore the experiences and perceptions of midwives providing perinatal bereavement care during the COVID-19 pandemic.
- (2) To explore the barriers and facilitators to providing compassionate bereavement care during the COVID-19 pandemic.

Consent and ethics

Ethical principles were upheld in this study (Gray et al., 2017) and ethical approval was granted in December 2020 from the HSE Mid-Western Area Research Ethics Committee (REC Ref:121/2020). Participation in the study was voluntary and informed written consent was obtained prior to data collection. Confidentiality and anonymity were preserved by assigning pseudonyms to participants and no identifiable information was included in the findings.

Study setting

This study was carried out in a stand-alone Regional Maternity Hospital located in a large metropolitan center in the Republic of Ireland. Bereavement care is provided by the multidisciplinary team with the support of two clinical midwife specialists in bereavement and loss. Ireland experienced a second and third wave of COVID-19 infections rates, resulting in level five public health restrictions for the duration of the study. The hospital was very

Table 1
Inclusion and exclusion criteria.

Inclusion criteria:
<ul style="list-style-type: none"> • Midwives who had experience of caring for bereaved parents during the COVID-19 pandemic • The ability to give informed consent • Midwives registered with the Nursing and Midwifery Board of Ireland
Exclusion criteria:
<ul style="list-style-type: none"> • Midwives with no experience of caring for bereaved parents during the COVID-19 pandemic • Student midwives • Agency staff • Midwives who had not given informed consent

sensitive to specific situations regarding pregnancy loss, stillbirth and unexpected complications and adapted visiting restrictions to meet individual women's needs to ensure that women had the on-site support of their partner.

Participant recruitment

Following ethical approval, recruitment commenced by circulation of a poster to clinical areas inviting midwives to contact the researcher to discuss the study and consider their participation. Midwives who expressed an interest in participating in the study and who met the inclusion criteria (Table 1) were provided with information about the study which included a letter of introduction, information leaflet and a consent form.

In accordance with qualitative research methodology and the intention to recruit information-rich cases purposive sampling was employed to ensure maximum variation in recruitment of midwives with a broad range of experience, practicing across clinical areas including labor ward, antenatal ward and Emergency Maternity Unit who had experience of providing bereavement care during COVID-19 (LoBiondo-Wood and Haber 2018). The inclusion/exclusion criteria are set out in Table 1.

Data collection

Data were collected through in-depth, semi structured audio recorded interviews conducted by the first author between December 2020 and January 2021. The first author was a clinical midwife practicing in the study site, known to the informants. Interviews lasted 20–60 min (average length of 30 min).

Interviews were guided by a pilot tested interview schedule consisting of open-ended questions and probes developed after a preliminary review of the literature and through discussion with a midwife specializing in bereavement care. Interviews were conducted face to face ($n = 1$) or by telephone ($n = 10$) according to the participant's preferences. Informed consent was obtained at the beginning of the interview through a signed consent form if face-to-face, or given orally and recorded in writing if by telephone. Face to face interviews took place at a time convenient to the participant adhering to COVID-19 public health advice in a non-clinical area in the hospital. Interviewing midwives about their experiences of providing bereavement care during a pandemic had the potential to arouse feelings of distress. In order to support interviewees, the participants were free to withdraw at any time during the interview and the participant information sheet had information about accessing employee assistance counselling services, which was reiterated at the beginning and end of interviews. Data collection ceased after eleven interviews as data saturation appeared to occur initially after nine interviews with the final two interviews serving to test the evolving themes. Data saturation was

determined on the basis there was a repetition of concepts and interviews offered no new information (Gugiu et al., 2020).

After completion of each interview, the researcher reflected on the process of data collection and interview content and documented brief field notes to capture contextual details, summarize main concepts, identify emerging codes as data analysis and collection proceeded in parallel. Interview audio files, transcriptions and field notes were stored in compliance with the Irish General Data Protection Regulation (GDPR) (2018).

Data analysis

Thematic data analysis was carried out, guided by Braun and Clarke (2013) six-step framework. Eight of the audio recorded interviews were transcribed verbatim by the first author after the interviews and three were transcribed by a professional transcriber who signed a confidentiality agreement. Step one of thematic analysis encourages familiarity with the interview content. During this step, accuracy of anonymised transcripts was confirmed by reading and re-reading transcriptions and listening to original recordings concurrently. In step two, initial codes were generated which involved manual, line-by-line, inductive open coding of all transcript data using a descriptive code and adding new codes as analysis progressed (Braun and Clarke, 2013). Following initial coding, step three entailed the generation of themes. Codes were refined and combined iteratively as data collection continued, and themes describing manifest content were developed. During step four, themes were reviewed for each interview and across interviews to determine that themes were an accurate representation of the data. The aim of step five is to 'identify the essence of what each theme is about' Braun and Clarke (2013 p.92) and to ensure themes are relevant to the research question. During step four and step five, the generation of themes and sub-themes was discussed and agreed by the authors. This led to step six and presentation of the findings consisting of themes, and subthemes, which are supported by quotations from participants (Braun and Clarke, 2013).

Rigour

Rigour in qualitative research is represented by the concept of trustworthiness, addressing issues of credibility, dependability, confirmability and transferability (Houghton et al., 2013) Lincoln and Guba's, 1985). The researcher had established a trusting relationship with the participants before interviewing so there was a willingness of the participants to exchange information which enhanced credibility (Bradshaw et al., 2017). Prolonged engagement with the data also improved credibility of findings. To ensure an accurate reflection of the participants views, audio recordings and transcripts were analysed using the structured thematic analysis process outlined by Braun and Clarke (2013) which has the potential to reduce bias (Mackieson et al., 2019; Lincoln and Guba, 1985).

Extracts from interview transcripts were presented in the findings section. Once interviews were transcribed the participants viewed the transcripts to ensure accuracy of the data. The researcher was acutely aware of all aspects of the research that were open to bias and took steps to recognise and limit any potential bias. Once preliminary findings were identified, these were presented to participants ($n = 4$) to establish if they fitted with their perceptions and experience of the research topic (Prion and Adamson, 2014). This increases confidence in the credibility of the findings (Thomas and Magilvy, 2011), ensuring that the researchers' interpretation of the data is a true reflection of the midwives' experiences and is not inadvertently influenced by the researchers own beliefs and values (Johnson et al., 2020). Rigor was addressed

Table 2
Demographic details.

	Number	% of total sample
Total no. of participants	11	
Gender		
Female	11	100%
Mean level of midwifery experience	14.5 years (1-34 years)	
Highest Level of Professional Qualification		
Bachelor of Science Degree	3	27.3%
Higher Diploma	5	45.5%
Master's Degree	3	27.3%
Further Professional Training		
Bereavement Specific Training	6	54.5%

through the use of the pilot study to test the method and interview schedule (Riffin et al., 2014). Furthermore, two researchers (AMP and MN) reviewed codes, themes and subthemes, and the use of direct quotations support verification of the accuracy of the data (Bradshaw et al., 2017). In addition, the research has provided a detailed systematic account of the research process and research setting to aid transferability of the original findings to another context (Morse, 2015; Bradshaw et al., 2017).

Findings

Demographic details of participants are provided in Table 2. Qualitative research aims to explore experiences of participants in a particular context, therefore, it is essential to acknowledge the social, cultural and educational context in which participants work (Polit and Beck, 2017). All participants were female and had practiced midwifery for between 1 and 34 years with a mean experience of 14.5 years reported. Five participants were dual qualified and three of the participants were educated to Masters level. Education related to perinatal bereavement and loss plays a pivotal role in preparing healthcare professionals to provide compassionate bereavement care (Health Service Executive, 2016). Five of the participants had not completed any perinatal bereavement care training. Over half of the participants ($n = 6$) had completed education in perinatal bereavement and loss. The sample included participants with experience of providing perinatal bereavement care from antenatal ($n = 9$) and intranatal ($n = 2$) clinical areas and this enabled a broad exploration of the phenomenon to address the research question. National Standards for bereavement care recommend that a system is in place to ensure continuity of care throughout the woman's in patient care (Health Service Executive, 2016). Continuity of care is provided on the antenatal ward as bereaved parents receive antenatal and postnatal care from the same midwife where possible as they return to the antenatal ward post birth.

Themes

Analysis of the data revealed two related themes that reflect the participant's experience of providing perinatal bereavement care during the COVID-19 pandemic: (1) Challenges of providing compassionate bereavement care during a pandemic. (2) Psychological effects and coping strategies utilized by midwives (Table 3). The theme 'Challenges of providing compassionate bereavement care during a pandemic' appeared to permeate all other themes. This theme incorporates three sub-themes; 'stranger in a mask', 'on their own' and 'virus first and woman-centered care second'.

Challenges of providing compassionate bereavement care during a pandemic

All midwives interviewed found bereavement care provision challenging in the context of COVID-19. Midwives expressed con-

cern on the impact the pandemic had on their ability to provide optimal care. Findings indicate that midwives attempted/struggled to provide woman-centre care within a new and changing health care environment. Participants described how facemasks, social distancing and lack of personal touch hindered their communication skills and impacted on their ability to engage with bereaved parents. However, midwives continued to provide the core components of compassionate bereavement care and utilised various strategies to compensate for the disruption of human connection. Visitor restrictions resulted in women not being able to access usual support structures and midwives were conscious of providing added support to compensate for this.

Stranger in a mask

Many of the midwives considered the use of Personal Protective Equipment (PPE) affected care provision to bereaved parents and suggested that it was a significant barrier to providing compassionate care. They described how they felt that the care they gave was now impersonal and made it harder to engage with the woman and her partner. Words such as "cold" "impersonal" and "stranger in a mask" were used throughout the interviews. Making a connection and building rapport with the woman while wearing a facemask was challenging and many of the participants felt that they had to change their communication approach:

"Before you could sit near somebody, even the closeness of sitting near someone when you're communicating with them. Now you're trying to stand two meters away from somebody so the closeness isn't there" Jenny.

Anna felt her non-verbal communication skills were impacted by the wearing of facemasks:

"Their memory of people supporting them is just their eyes. How can you communicate fully with just eyes?" Anna.

Findings suggested that midwives utilised various techniques to connect with bereaved parents and mitigate against the "new normal" of mask wearing. For example, to compensate for the wearing of PPE a midwife would briefly remove her mask to facilitate a greater connection with parents:

"Sometimes I would remove my mask very quickly for a second at a 2-meter distance just so they can see what I look like" Margaret.

'On their own'

Visitor restrictions created additional challenges in providing perinatal bereavement care. In the case of bereaved parents, partners were permitted to stay with the woman if she was accommodated in a single room. Generally, women experiencing early pregnancy loss are accommodated in a three-bedded room therefore, partners were unable to stay. Midwives were very aware that this impacted on support structures available to women at this time:

"She was on her own the whole day and she had no one." Una.

Table 3
Data analysis.

Themes	Subthemes
Challenges of providing compassionate bereavement care during a pandemic	'Stranger in a mask' 'On their own' 'Virus first and woman-centred care second'
Psychological effect and coping strategies utilised by midwives during a pandemic	Fear of cross infection 'All in it together'

Participants were conscious of the importance of partner support when caring for bereaved parents and they found themselves: “constantly apologising for this visitor restriction”. Midwives were particularly cognisant of the impact of restrictions when women were on their own when receiving bad news:

“Just that initial time of finding out women are on their own. I just find that aspect so difficult for them and challenging for me as a midwife.” Penny.

With no support person present midwives felt they needed to bridge the gap and provide emotional support to the bereaved woman. However, this was often challenging in the context of busy clinical environments:

“I just found it very difficult trying to help someone through their grief when they didn’t have the support of their partner. I just felt I had to give them more of my time than you probably had really.” Karin.

Prior to the pandemic, services such as photographers and professionals who create clay impressions of foot and hand prints were provided by external professionals. However, non-essential staff such as professionals who created mementoes for parents of their baby’s life were not permitted access to the hospital. During the pandemic midwives recognised the importance of these keepsakes and took on this responsibility of creating mementos for parents.

Midwives also expressed concern about support structures the bereaved parents would have available to them on discharge. They were concerned that due to public health restrictions bereaved parents were not meeting many of their family and friends. These usual supports may also be unaware of the pregnancy loss and this could contribute to the overall stigma of bereavement experienced by women.

“Some people weren’t going to work and hadn’t told people they were pregnant. I found some parents found that a comfort and didn’t need to let people know about their loss. On the other side of that it’s not addressing the issue of bereavement.” Orla.

In addition, participants worried that the social isolation associated with COVID-19 restrictions may lead to a more complex and prolonged grieving process:

“Feeling isolated and grieving at home on their own can be detrimental and I’ve seen that. People feel very much alone as they haven’t shared the experience with others.” Nora.

‘Virus first and woman-centered care second’

Therapeutic touch is an integral part of human interaction and is a large part of how midwives build rapport, ‘empathise’, show concern and provide comfort to bereaved parents. Participants spoke about how difficult it was not to be able to provide comfort such as a hug to the bereaved woman:

“Touch would be a huge part to empathise with them now unfortunately with social distancing we are not able to carry that out.” Orla.

Midwives described a sense of cognitive dissonance between how they previously provided bereavement care and what was

now possible to provide within the bounds of COVID-19 guidelines. This created a sense that it was *“virus first and patient care second”*.

“I am trying to physically distance myself when everything in my training and experience in working with these women is about the importance of touch” Margaret.

Participants felt the recommended contact time of fifteen minutes with women was not supportive of optimal bereavement care and impacted on emotional support provision. This resulted in participants expressing concern and guilt that the care they gave during the pandemic was not enough.

“You are always conscious of how long you can spend in the room with these parents. You can’t put a time on the care you give” Una.

“And guilt is another factor that comes into it as you feel guilty that you haven’t given the highest level of care you can give to a couple” Jenny.

Psychological effect and coping strategies utilized by midwives during a pandemic

The second theme identified through data analysis reflects the psychological effect on midwives providing bereavement care during a pandemic. The psychological effects related to the COVID-19 pandemic was influenced by many factors, and are reflected in the subthemes, fear of cross infection and concern for the bereaved couple.

Fear of cross infection

This subtheme explores the psychological impact of providing bereavement care while under the threat of contracting COVID-19 or transmitting the virus to women, their partners or their own families and loved ones. The fear of contracting the disease was at the forefront of participants minds:

“You also worry about cross infection and picking up something and potentially bringing in something from one room into a couple who are bereaved, or bringing it home to your family as well” Emma.

The focus of concern extended to the unknown effects of COVID-19 infection for pregnant women and the possible link of infection to miscarriage and stillbirth. Marie was nervous of what she would say if parents asked if COVID-19 was the reason for their loss:

“That poor couple were always thinking did COVID in some way contribute to the death of their baby. What could I say to that?” Marie.

Although midwives faced added challenges in providing care during pandemic certain strategies were implemented to mitigate against this. Colleague support and mindfulness were found to be helpful and most effective.

‘All in it together’

Midwives preferred to seek support by approaching colleagues who shared their experience of providing perinatal bereavement

care in the context of a pandemic. The presence of an understanding network of support from colleagues was relied upon and described by several participants as providing a sense of community:

“My biggest support is the people I work with. We are a great team and all look out for each other.” Gina.

The midwives described the psychological vulnerability they felt as they negotiated working in the midst of a pandemic and described benefitting from having colleagues with whom they could share thoughts and concerns. They were all in this together as none of them had faced such unknown circumstances at work before:

“Our colleagues, that feeling that we were all in it together and we needed to pull together to look after the patients and ourselves.” Nora.

Four of the midwives interviewed felt that going to work and meeting people during the pandemic beneficial to their own mental health and wellbeing:

“For me personally I found working during the pandemic a help. I still had face to face contact with colleagues and friends especially during the level five restrictions”. Penny.

Assistance from colleagues extended beyond psychological support to team problem solving and the identification of solutions to challenges that emerged as result of the COVID-19 restrictions. Anna describes a dilemma she came across where a couple were stopped at a Garda checkpoint on the way to the hospital to give birth to their stillborn baby. On mentioning this to her colleague, they collectively identified a solution to help the bereaved parents on discharge from hospital:

“She had been in a similar situation and rang up the Garda station for the parents to get a Garda (policeman) escort home which they did. I really do feel that talking over events with colleagues helps us all. If she hadn't mentioned it, I would never have thought of ringing up the Garda about getting an escort to prevent further grief to the family” Anna.

A second support strategy employed by midwives was attendance at mindfulness sessions. During the pandemic mindfulness sessions were facilitated for staff during working hours. Many of the midwives availed of these sessions and found them very helpful in their own self-care:

“I think the mindfulness sessions for staff are helpful. It helps you to recharge your batteries” Karin.

Discussion

There is widespread agreement that the provision of compassionate bereavement care is challenging for health care professionals (Jonas-Simpson et al., 2013; Nash et al., 2018; Laing et al., 2020). This research echoed this sentiment however, the COVID-19 pandemic created unprecedented and additional demands for midwives providing bereavement support as it created significant disruption to human connection and communication.

Midwives in this study identified that COVID-19 guidelines relating to IP&C measures negatively impacted on their ability to provide quality bereavement care by interrupting human connections. Both verbal and non-verbal communication has been demonstrated to be integral components of compassionate bereavement care (Kelley and Trinidad, 2012; Quinn, 2016; Cockell, 2020), and were significantly impacted by the mandatory wearing of masks, maintaining social distancing and time limitation to contact times with women. In this research, facemasks were found to have impacted on participants ability to build a rapport and communicate with women. A finding supported by Spillane (2020) who found that mask wearing created a barrier to effective communication and significantly impacts on non-verbal communication.

Social distancing removed midwives ability to provide therapeutic touch and was viewed as a significant barrier to providing empathic care. These findings are supported by research undertaken by Menage et al. (2020) who found communication and touch were key elements in women's experiences of compassionate care. Bailey and Nightengale (2020) also agree that without the “hands on” element of care, the ability to build a rapport with women will be diminished.

Coxon et al. (2020) acknowledges the radical change the COVID 19 pandemic has had on the basic elements of the midwife woman relationship as a result of cross infection reduction strategies and the unknown impact this will have on the wellbeing of women and their families.

Providing quality empathic care requires time and time limits imposed on contact times with women challenged midwives' ability to provide care. This concurred with a study by Erland and Dahl (2017) in relation to the Ebola virus where health care professionals felt helpless when they could not help patients in the way they wished while adhering to strict IP&C measures. Prior to the pandemic professionals came into the hospital to make mementos for bereaved parents. The making of memories now fell to midwives, many of whom felt ill prepared for these tasks. Mementos such as photos and prints are seen to be cathartic to grieving parents and may help parents in coming to terms with their loss (Rådestad et al., 2011; Erlandsson et al., 2013). While it was clear that midwives understood the importance and value of these mementos, undertaking these tasks also added to the challenge of providing care.

All of the midwives in this research expressed negative psychological responses to the pandemic. Managing their own fear and anxiety of contracting the virus and potentially spreading it to family, colleagues, women, babies and their families was found to be a significant stressor for midwives. This finding echoes the experiences of healthcare professionals during the Ebola epidemic (Erland and Dahl, 2017; Jones et al., 2017; Kollie et al., 2017), and is supported by research undertaken in Ireland, Turkey and China (Aksoy and Koçak, 2020; Huang and Zhao, 2020). It was found that nurses experienced adverse psychological effects due to the COVID-19 pandemic (Aksoy and Koçak, 2020) including higher levels of anxiety compared to the general population (Huang and Zhao, 2020). While, Renfrew et al. (2020) found a heightened sense of fear and anxiety can dominate care at this time. Anxieties around a healthcare professionals' personal safety may conflict with their professional duty to provide care (Wu et al., 2020), which underlines the complexity of issues encountered by healthcare professionals and the dissonance they are required to reconcile (Rambaldini et al., 2005).

In this study, midwives raised concerns about how the pandemic would affect the parents' bereavement journey. It is acknowledged within the literature that social isolation and changes to cultural grieving practices as a result of COVID-19 restrictions may lead to a more complex and prolonged grief reaction (Carr et al., 2020). Furthermore, midwives felt that social isolation could contribute to the stigma of perinatal bereavement which acts as a barrier to supporting bereaved parents (Heazell, 2016; Horton and Samarasekera, 2016). Furthermore the literature acknowledges that social support can help grieving families (Cockell, 2020). Midwives worried about the unpredictable nature of the virus and the unknown effect it could have on pregnancy. There is emerging data available on the link between COVID-19 infection during pregnancy and an increase risk of stillbirths (Homer et al., 2021).

Participants in this research utilized a number of coping strategies. Colleague support and mindfulness were the most relied upon strategies, with the majority of midwives declining to make use of any formal psychological supports that were available to them.

All of the participants in the study stated that they relied on colleagues' support to help them cope. This finding is reflective of other literature in this area (Nash et al., 2018; Meller et al., 2019; Laing et al., 2020). Laing et al (2020) found colleague support essential in providing emotional support to midwives practicing during the pandemic. Similarly a high degree of collegiality was found amongst midwives in New Zealand which supported safety in the workplace during the COVID-19 pandemic (Dixon, 2020). In previous pandemics healthcare professionals expressed a fear of going to work (Jones et al., 2017; Kollie et al., 2017) however in this study midwives found going to work provided a structure and degree of normality in their lives. Participants found working and meeting people a comfort and did not experience social isolation that other healthcare providers had experienced when providing care during the COVID-19 pandemic (Huang and Zhao, 2020).

The literature recognizes that organizational stress maybe harmful for healthcare professionals mental and physical health and well-being (Melnyk et al., 2013; Foster et al., 2020). It has been suggested that midwives and nurses might experience heightened stress levels during a public health crisis (Shorey and Chan, 2020). Pollock et al. (2020) suggests that midwives' psychosocial well-being and physical protection needs to be considered alongside how best to support pregnant women and their families. Walton (2020) acknowledges the innovation, imagination and kindness of midwives who continue to be 'with women' and provide care despite fears for their own health and safety and that of women and their families. In the study site the impact of the stress associated with COVID-19 was recognized and a mindfulness intervention was offered to employees. Many of the participants availed of this intervention. Behan et al. (2020) suggests that mindfulness offered during a pandemic may allay fear and anxiety and potentially benefit employees long-term mental health.

Recommendations and implications for practice

This study has implications for midwifery practice, education and research. The findings of this research suggest that the COVID-19 pandemic had a significant impact on bereavement care provision. As such, further research should explore the experiences of families who receive perinatal bereavement care during the COVID-19 pandemic. In this study it was evident that midwives attempted to mitigate against the disrupted human connections and communication caused by IP&C recommendations. The effectiveness of these techniques merit further exploration. Midwives who have been affected by providing care during COVID-19 to bereaved parents need a more structured support system in place. Health care organizations have a responsibility to address how employees can be supported to deal with fears of contracting the virus, and the emotional challenges they encounter (Bruffaerts, 2021). Techniques which have been demonstrated to be beneficial in providing psychological support to staff need to be implemented in a structured and sustainable way. Relevant education on adapting compassionate perinatal bereavement communication and care in the context of IP&C measures including mask wearing and social distancing and taking mementos should be provided for staff.

Limitations

This study was set in one stand-alone regional Maternity hospital. Although transferability may be assessed by the reader based upon the provision of rich description of the study setting and findings, we cannot claim that they reflect the experiences of midwives working in alternative settings or cultures where different levels of COVID-19 restrictions may have been implemented. Although the researcher had a professional relationship with many

participants, the interviews were conducted away from the clinical area and a participatory interview was encouraged. The participants freely and articulately recounted and shared their experiences. This study had a small sample size from one maternity hospital in one country, which is consistent with qualitative methodologies which privilege context rich narrative data (Karaniokola, 2019). Despite the limitations, the aim of the study, which was to capture midwives' perceptions and experiences of perinatal bereavement care provision during a pandemic, was achieved.

Conclusion

This study, explored midwives' experiences of providing bereavement care during the COVID-19 pandemic. The findings of this study indicated that the pandemic brought unprecedented challenges to midwives when providing perinatal bereavement care. Mandatory IP&C measures significantly disrupted human communication and connections. Midwives in the study expressed an in-depth understanding of the core components of quality perinatal bereavement care and utilised techniques to optimise care while adhering to COVID-19 guidelines. The impact of working during a pandemic was found to have significant psychological impact on the participants. A number of strategies were identified which were found to be beneficial including mindfulness and colleague support.

Declaration of Competing Interest

We have no conflict of interest, financial or otherwise to declare. Neither the manuscript nor any parts of its content are currently under consideration or published in another journal. Ethical approval was granted in December 2020 from the HSE Mid-Western Area Research Ethics Committee.

CRediT authorship contribution statement

Annmarie Power: Conceptualization, Methodology, Software, Investigation, Data curation, Writing – original draft. **Sandra Atkinson:** Visualization, Writing – review & editing. **Maria Noonan:** Software, Validation, Data curation, Formal analysis, Investigation, Writing – review & editing, Supervision, Project administration.

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