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UCD School of Nursing, Midwifery and Health Systems

Bereavement Care Education & Training in Clinical Practice -

Supporting the Development of Confidence in Midwifery students

In the National Maternity Hospital

Nursing & Midwifery Planning & Development Unit Dublin South, Kildare and Wicklow

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A Joint Research Network Project

Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in 4th year BSc Midwifery and Higher Diploma Midwifery students in the National Maternity Hospital.

Final Report

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Chapter 1: Introduction

Abstract

Background

Midwives are in the ideal position to sensitively gauge parent's needs and support them when they suffer a perinatal bereavement or pregnancy loss. However, there are reports of substandard and inconsistent bereavement care in the maternity setting, and bereavement training is described as being inadequate and sparse. Midwives are suggesting that they do not feel prepared for this aspect of their job, upon qualification. Education has a significant, direct, impact on bereavement care provision and in turn, psychological outcomes for healthcare workers and parents. Given the demand on midwives to provide evidence-based care, it is essential to find ways of making training efficient, intellectually rigorous, and well-integrated into clinical practice.

Educational Intervention

In 2016, the HSE developed the 'National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death', to improve and harmonise the care of a very vulnerable group of women and their partners and families. These standards included a provision for better education for all staff and health care professionals working in Irish maternity care services. In response, a one-day interactive Educational Training Workshop in Bereavement Care (ETWBC) was developed for student midwives in a Dublin Maternity Hospital.

Research Design and Methods

The ETWBC was evaluated on content and process using a longitudinal sequential mixed methods design. Quantitative data was collected 3 time points; pre and post workshop and at 3 month follow-up [Outcome Evaluation], using the 'Perinatal Bereavement Care Confidence Scale' (Kalu et al, 2016;2017) and the 'Self-Compassion Scale-Short form' (Raes et al, 2011).
Thirty nine of the 41 Higher Diploma and 4th year BSc midwifery students participated in the workshop and 97.44% (n=38) of the participants completed the questionnaires at all 3 time points. Data from the questionnaires were analysed using SPSS. Qualitative information was collected to evaluate the experience for students of participating in the workshop and discuss their future bereavement care needs, using two focus groups, using two focus groups (n=12 Midwifery Students) [Process Evaluation]. This data was analysed using Thematic Network Analysis.

Results

The ETWBC was effective in increasing student's confidence; Bereavement support skills [$F(2,72)=21.150$, $p<.000$, partial eta squared= 0.370] and Bereavement support knowledge [$F(1.6,60)=48.460$, $p<.000$, partial eta squared = 0.567] to provide bereavement care and effective in improving students' self-awareness. There was no significant increase in the students' perceptions of organisational support or self-compassion. The role-playing aspect of the workshop received the most positive feedback. Lack of exposure to bereaved parents was highlighted as a barrier to gaining further confidence.

Conclusion

The results of this study suggest that all BSc Midwifery and Higher Diploma Midwifery curricula would benefit from having such an interactive workshop to increase students' confidence in the delivery of effective bereavement care. The content of this workshop can be utilised in any maternity setting in Ireland and is recommended, not only for the midwifery cohort but all staff members looking after parents suffering perinatal bereavement or pregnancy loss. More support and encouragement from senior staff is needed to assist the students' in gaining much-needed exposure.

1.2 Introduction

The word ‘Silence' is used repeatedly, in literature, to describe experiences of perinatal death (Rowlands & Lee, 2010; Rådestad *et al*., 2014). Not a calm, peaceful silence, but a deafening, empty, heart wrenching silence - silence at the time of diagnosis, when the midwife doesn't know what to say; silence in the delivery room when the midwife passes the sleeping baby to the mother; and sometimes just silence... and hand holding... and contemplation (Gold, 2007; Downe *et al*., 2013). In that silence, midwives bond with mothers and fathers, and share in their experience. Emotions shift from joyous expectations to an explosion of grief and loss. Being the one who provides comfort and support at this moment can be rewarding but also draining, owing to the added burden of managing one's own emotions (Asplin *et al.*, 2012; Gandino *et al.*, 2017).

1.3 Standards and Recommendations

> *“Staff education and training programmes are mandatory and should cover the key elements of these national standards, specifically addressing how to support parents’ or families’ preferences and values”.*
>
> HSE (2016, pp. 54)

Highlighted in the literature (HSE, 2016) is the importance of higher quality bereavement care training and researchers have recommended that the following be included in any training programme: Communication Skills; The Importance of Memory Making; Culturally Sensitive Care; Shared Decision Making and Self Care (Sayed *et al.*, 2013; Williams *et al*., 2008). These recommendations mirror the many official recommendations and standards set out by the Health Services Executive (HSE) (2010; 2014a; 2014b; 2014c; 2016); the Department of Health (DoH) (2016); the Nursing and Midwifery Board of Ireland (NMBI) (2014); and the UK bereavement charity organisation Stillbirth and Neonatal Death Society (SANDS) (2011); and the Irish Hospice Foundation (IHF) (2012). However, a large number of these have yet to be implemented.

Upon registration, a midwife is bound by the ‘Scope of Nursing and Midwifery Practice Framework' (NMBI, 2015) and the ‘Code of Professional Conduct and Ethics' (NMBI, 2014). Adhering to the principles laid out is a condition of a midwife's registration. Within the scope of practice is the assumption that a registered midwife demonstrates and maintains competency in his/her practice of midwifery (NMBI, 2015). The NMBI also states that the highest possible care should be given to the people in their care (NMBI, 2014). ‘Compassion, Care and Commitment', are the three core midwifery values set out by the DoH (2016) and most midwives strive to live and work by these values. The DoH (2016) defines ‘Care' as having ‘...required knowledge, skill and competence...' to provide care. Included in the ‘Commitment' value is the provision that midwives engage in effective communication (DoH, 2016). The HSE and NMBI highlight their commitment to supporting nursing and midwifery staff to display and sustain these values, through employment and managerial process, education programmes, standards of care and regulatory processes.

Some of the many bereavement standards, set out by the HSE (2016), in their new document entitled ‘National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death', focus on the training and education of staff; providing culturally sensitive care; involving the parents in the decision-making process; making parents aware of available services; as well as staff support and self-care. The HSE & Irish Hospice Foundation (IHF) (2012) also stipulates the importance of education and training in the area of bereavement, as well as the provision of staff support. The literature review, to follow, is evidence that midwifery and educational institutions are not implementing sufficient training in the area of bereavement, as recommended by the standards and recommendations mentioned above. The need for improved bereavement education, in midwifery,

has been highlighted since as far back as the 1980's and 1990's (Gardner, 1999). As well as the improvement of training the significance of staff support and debriefing, after an adverse event or bereavement, have repeatedly been voiced as invaluable to health care workers positive mental health (Cortezzo *et al.*, 2015; Wallbank & Robertson, 2013). However, while conducting the literature review, no government level policy or recommendation, was found, to guide institutions on methods of improving self-care practices, and increasing self-compassion. This should be made priority due to the effects of compassion fatigue and burnout on midwives, the women in their care, and the midwifery workforce as a whole (Wallbank & Robertson, 2013).

Chapter 2: Literature Review

"*I'm afraid of upsetting them further*": Student Midwives Educational Needs in Relation to Bereavement in the Maternity Setting.

2.1 Introduction

In the 21st century, in Western society, when a woman passes through the first trimester of pregnancy, she rarely expects anything but a healthy outcome (Kelley & Trindad, 2012). 'Overwhelming shock,' 'horror,' 'shame' and 'feeling broken' are just some of the words used to describe parents' feelings when a stillbirth, neonatal death or miscarriage occurs (Donovan *et al.*, 2014; Koopmans *et al.*, 2013; Kelley & Trindad, 2012). A midwife, who is caring for a dying infant, and supporting their family, encompasses an extraordinarily unique and intimate encounter with grief, pain, and loss (Buder & Fringer, 2016). It can cause anxiety and sadness for midwives and can promote a sense of guilt, stress, and exhaustion when attempting to comfort and assist the bereaved parents through this distressing time (Ben-Ezra *et al.*, 2014; Cortezzo *et al.*, 2015; Fenwick *et al.*, 2007; Gandino *et al.*, 2017). Student midwives are affected more severely, as they also battle feelings of inadequacy and fear, due to the lack of exposure and training in this area of midwifery (Begley, 2003; Coldridge & Davies, 2017; McKenna & Rolls, 2011).

A discussion on the impact perinatal bereavement has on women and their families, as well as the effect that the care received, has on their experience, is presented in this literature review. The impression grief and bereavement leaves on midwives, and student midwives is also outlined. Previous educational interventions in bereavement care are examined, followed by a discussion on the strengths and limitations, of these approaches.

A review of the literature was undertaken in databases such as Cumulative Index to Nursing and Allied Health Literature (CINAHL); Association for Death Education & Counselling; PUBMED; Cochrane Database and National Council for Palliative Care, using the keywords "bereavement education"; "student midwives"; "stillbirth"; "bereavement training"; "perinatal bereavement"; "midwives stillbirth"; "midwives neonatal death" and "midwives miscarriage". Due to the vast changes in attitude toward perinatal bereavement care, in recent decades, the search criteria were limited to articles written from 2000-2017, for the most part. The search was further limited to the English language only. Data was also collected from manual searches, including guidelines, standards and charity organisations about this topic. Finally, scanning references from retrieved studies were also performed.

The key themes identified were: The impact of pregnancy loss and perinatal death on families: short and long-term; The implications of bereavement care received by families: positive and negative; What families need from health professionals at a time of loss; The impact of working as a midwife; The impact of bereavement on midwives; The psychological impact of being a student midwife; Student midwives experiences of bereavement; Gap in bereavement education; Existing bereavement educational interventions.

2.2 Classifications and Statistics

Perinatal death is classified differently by individual countries and organisations. It is described by the World Health Organisation (WHO) as a death occurring at and over 22 completed weeks' gestation, during childbirth and up to 7 completed days of life. Miscarriage is defined as the spontaneous loss of a pregnancy before the fetus reaches viability, which is 24 weeks gestation

(HSE, 2014a; NICE, 2011). Second-trimester miscarriage is a pregnancy loss between 12 and 24 weeks gestation (HSE, 2014c; NICE, 2011). The global burden of perinatal death is vast. Worldwide, there are 2.6 million stillbirths and 2.1 million neonatal deaths annually (Child Mortality Collaborators, 2016). In Ireland, approximately 1 in every 250 births is stillborn, and 1 in every 435 live births dies in the first 7 days of life (HSE, 2014b). Miscarriage statistics are difficult to deduce, as there is often no formal data gathered in maternity settings. RCOG (2011) suggest that an average of 1 in 5 pregnancies miscarry. An estimated 0.8-2% of pregnancies end in second-trimester miscarriage (NICE, 2011; Cullen *et al.*, 2017). Recurrent miscarriage is defined as 3 or more consecutive miscarriages (NICE, 2011). Approximately 1% of couples trying to conceive suffer recurrent miscarriages (NICE, 2011; RCOG, 2011). Major congenital anomaly and maternal vascular malperfusion are the primary causes of perinatal death at approximately 25% each (National Perinatal Epidemiology Centre, 2016).

In 2014, in Ireland, approximately 15% of stillbirths were unexplained (National Perinatal Epidemiology Centre, 2016). In an informative UK survey, undertaken by the National Perinatal Epidemiology Unit (NPEU) (2014), it was noted that just over 50% of women who had a stillbirth had problems with their pregnancies, with most of this cohort having received additional specialist care. These statistics can be difficult for parents to acknowledge. Women who consider themselves as taking care of themselves and their babies perceive themselves as protecting their baby against stillbirth because they are ‘doing everything right' (Kelley & Trinidad, 2012).

2.3 Personal Impact of Perinatal Loss

> *"The quality of care that bereaved parents receive has a profound effect on their wellbeing and that of their families, both now and in the future. Good care cannot remove the pain of their grief, but poor care makes everything worse"*
>
> Neal Long, Chief Executive, SANDS (2016, pp. 2).

Women experiencing pregnancy and perinatal loss find themselves being forced into “handling the unimaginable” (Malm *et al.*, 2011, pp. 53). Although one study concluded that gestational age correlates with grief scores (Lasker & Toedter, 1994), other's attest that the impact of perinatal loss is not defined by the gestation, or an infants’ age, at the time of the loss, but by the personal meaning of, and the level of investment in, the pregnancy (Stratton & Lloyd, 2008, Robinson *et al*., 1999). Upon confirmation of a baby's demise or impending demise, mothers experience feelings of profound grief, broken expectations, anxiety, and a loss of power and competence through feelings of guilt (Koopmans *et al*., 2013; Malm *et al.*, 2011; Kelley & Trinidad, 2012). People in the developed world are never prepared for this type of loss, and this causes bereaved parents to feel the utter shock as well as a failure (Caccaitore & Bushfield, 2008; McCreight, 2008; Murphy, 2012; Rowa-Dewar, 2002). A participant in one study described herself as being "...part of a ‘club' that I never knew about or wanted to know about..." (Caccaitore & Bushfield, 2008, pp.79). Fathers have feelings of helplessness and frustration and often bury their own feelings to be strong for their partner (Samuelson *et al.*, 2001; McCreight, 2004).

Long before the gestational age of viability, the bonding process begins between the infant and the parents, as they prepare for their new journey as mother and father (Malm *et al.*, 2011; Peters *et al.*, 2015). Today's technology of early pregnancy tests and ultrasound scans make it easier for fathers to bond with their unborn child (Kendall & Guo, 2008; Robinson *et al.*, 1999). A mother gets to know her baby in a way that no-one else does, feels her baby's movements and envisages what life is going to be like with her baby (Peppers & Knapp, 1980, cited in Harmon *et al.*, 1984, pp.68). A number of theorists reiterate this assumption of attachment, in their views on loss, all confirming this intense bond, even from early in the pregnancy (Klaus & Kennel, 1976, cited in Harmon *et al*., 1984,

pp.68; Peppers & Knapp, 1980, cited in cited in Harmon *et al*., 1984, pp.68). Bowlby (1969, cited in Cacciatore & Bushfield, 2007, pp.62), the renowned psychiatrist, in his theory of attachment, does not suggest that attachment is contingent on time spent in a relationship, or age, or interdependency, but instead recognised the complexities and scope of attachment. A baby can represent hope for the future, a potential for fulfilling dreams and a chance to alter the course of a lifetime (Arnold & Gemma, 1994, cited in Avelin *et al*., 2013, pp.669). When fetal or infant demise is experienced, it is not just the baby that they mourn; it is also the lost role of parenthood (Malm *et al.*, 2011). Countless research papers support this notion, and the one commonality they share is the evidence that this intensely painful and traumatic life event leaves a long-term negative impression on all surviving parents (McCreight, 2004; Downe *et al.*, 2013; Gold *et al.*, 2014; Lee, 2012; Love, 2007; Murphy & Caccaitore, 2017).

The long-term effects can be profound. Firstly, miscarriage and stillbirth increase the possibility of relationship breakdown between parents (Shreffler & Caccaitore, 2012). Misunderstandings and resentment arise as the parents' coping styles differ (Rowa-Dewar, 2002). Also, perinatal death changes how the bereaved parents see themselves within their social circle (Caemaex *et al.*, 2013). Many parents believe that their friends and family do not categorise them as parents, and do not recognise their loss, making them feel isolated and stigmatised (Cacciatore & Bushfield, 2007; Caemaex *et al.*, 2013; Kelley & Trindad, 2012; Murphy, 2012). They often avoid mentioning the taboo subject of their loss, for fear of upsetting people (Murphy, 2012). Gold *et al.* (2014; 2016) have compiled extensive research into the area of the long-term risk of psychiatric symptoms. They deduced that following miscarriage, stillbirth and neonatal death, up to 25% suffer profound symptoms years later. Furthermore, Gold and colleagues also concluded that bereaved mothers are 7 times more likely to develop post-traumatic stress disorder (PTSD) and are 4 times more likely to have depression. They are also twice as likely to have anxiety disorders and social phobia. Interestingly, according to Gold *et al*., only a minority of these women receive psychiatric treatment. It must be noted that that existing mental health illness is a risk factor for perinatal death, and Gold *et al.* (2014) did find a higher rate of pre-existing mental health issues in the bereaved cohort. This finding means that a proportion of the bereaved cohort is particularly vulnerable, following such an emotionally wrenching event (Gold *et al*., 2014). Unresolved grief can also carry over into subsequent pregnancies and can affect attachment (Robinson *et al.*, 1999). Also, a higher risk of PTSD has been reported in bereaved mothers during subsequent pregnancies (Koopmans *et al.*, 2013).

Surkan *et al.* (2008) and Caccaitore & Bushfield (2007) demonstrated the importance of mothers engaging in discussions with, and receiving support from, partners and social circles due to the positive influence it has on their mental health. The care received, in the hospital setting, at the time of the loss, also has long-term implications on parent's mental health (Kelley & Trinidad, 2012; Ellis *et al*., 2016; Lee, 2012; Lasker & Toedter, 1994). According to Engler & Lasker (2000), the support a mother receives following the death of her child is the single most crucial factor in predicting the nature of the grief process that she will experience.

2.4 Impact of Care Received

Parents experience transient, but overwhelming, feelings of numbness, anger, devastation, and grief following bereavement. Having to go through the delivery experience adds to the burden at this profoundly challenging time (Kelley & Trindad, 2012). Midwives, in the forefront of these parents' care, are in the ideal position to sensitively gauge parent's needs and support them to say goodbye (Kelley & Trinidad, 2012). The HSE (2016) acknowledges this, and developed the ‘National

Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death', in order to improve and harmonise the care of this vulnerable group of women and their partners. Reports on bereavement care indicate inconsistencies. Some studies show satisfaction by parents (Cullen *et al.*, 2017; Erlandsson *et al.*, 2011; Lasker & Toedter, 2001). Positive tangible and emotional care received, from health care workers, was identified as having a hugely positive impact on grieving parents (Gold, 2007; Lee, 2012; Meyer *et al.*, 2006; Rådestad, 1996; Séjourné, 2010, Williams *et al.*, 2008). Gold, *et al.* (2010) undertook a systematic review of parent experiences with health providers after the death of their baby. They found that parents find comfort in providers who stay with them; let them cry; show emotion themselves; treat them as parents' despite the loss; handle their babies in a caring manner and use small gestures, such as holding the mother's hand or brushing her hair. Giving honest answers and keeping parents' informed, as well as taking time to talk to them, and allowing them to talk openly, are also seen as hugely supportive gestures (Gold, 2007). There is also a great importance in tailoring care for each individual (Fenwick *et al.*, 2007). Culture, traditions, and religion also influence the way people mourn (Kendall & Guo, 2008). Therefore, the midwife should instigate open, nondirective communication, without allowing his/her own beliefs to interfere with the family's style of grieving, or make assumptions, based on peoples' appearance (Basile & Thornsteinsson, 2013; Koopmans *et al.*, 2013; Schott & Henley, 2007). There appears to be a lack of cultural competency in midwifery and nursing education (Attard *et al.*, 2014). This lack of knowledge can confuse the midwives role in providing spiritual care, avoidance of spiritual matters, and even a fear of imposing their philosophy onto others (Attard *et al.*, 2014).

Basile & Thornsteinsson's Australian study (2013) showed that there had been a marked increase in the satisfaction levels for the care received, in hospitals, over the past two decades, yet, still, almost one in four bereaved parents leave the hospital disappointed with the care received. This finding is not dissimilar to other studies, all reporting substandard and inconsistent care (Cacciatore & Bushfield, 2007; Downe *et al.*, 2015 Erlandsson, *et al.*, 2011; Lee, 2012; Rådestad *et al.*, 2014). Gijzen (2016) suggests that midwives need to offer grieving parents emotional, intrinsic and informational support.

2.4.1 Informational Support

Informational support involves empowering parents in the decision-making process, as well as imparting relevant information regarding support groups, social services, and what to expect at different stages of the bereavement and delivery process (Caeymaex *et al.*, 2013). As the ability to digest information can be affected by parents' overwhelming emotions, information should be delivered compassionately, and offered repeatedly, and the timing of information delivery should be considered (Gijzen *et al.*, 2016; McGuiness *et al.*, 2014a; Rådestad *et al.*, 2014; Séjourné *et al.*, 2010; Williams *et al.*, 2008). The critical element of informational support is that it should be well informed and given well. The midwife should be prepared for these difficult conversations; should retain a calm environment and should take their time (Säflund, 2004). Offering information, in writing, such as in leaflet form, will give the parents something to refer to if unclear, or if information wasn't taken in correctly. Nineteen percent of participants, in a recent Dutch study, by Gijzen *et al.* (2016) mentioned limited informational support, with some people looking for information on the internet.

Encouraging shared decision making is a crucial aspect of informational support. Shared, as opposed to paternalistic decision-making, is a good compromise between parents' desire to be involved and their difficulty in understanding all of the information and implications involved (Caeymaex *et al.*, 2013; Schott & Henley, 2007). The percentage of parents who are involved in the

decision-making process, regarding the care of their baby, needs to increase (NPEU, 2014). Parents' experience less grief, long-term, if the responsibility of making decisions is shared (Caeymaex *et al*., 2013; Shelkowitz *et al.*, 2015; Sullivan *et al.*, 2013; Williams *et al.*, 2008). Parents value being given options, and missed opportunities can be a predominant component of parents' feelings of regret (Shelkowitz *et al.*, 2015). Whether to see and hold the baby is probably the biggest decision a parent will make in the immediate postnatal period, and the vast majority of literature recommends it, for its short and long-term benefits, such as helping to validate the baby's status; reducing regret; imprinting the baby in one's memory and reducing anxiety and depressive symptoms (Cacciatore *et al.*, 2008; Rådestad *et al.*, 2009; Sullivan *et al.*, 2013; Wilson *et al.*, 2015). There are a few who disagree with this recommendation (Hughes *et al.*, 2002). Some people choose not to see their baby for cultural reasons, or to avoid attachment, or in an attempt to reduce their guilt and suffering (Sun *et al*., 2014). Even though these opposing recommendations have been refuted by many, it is a reminder of the importance of individualised care. Erlandsson *et al*. (2013) suggest assumptive bonding, proposing that asking a mother whether she would like to see and hold her baby is an unnatural question. Mothers of live babies are not asked this question. They suggest that midwives should tenderly treat the stillborn as if it is a live born baby. This act will allow mothers to feel less frightened and more natural and comfortable when handed their child (Erlandsson *et al.*, 2013). Rådestad & Christofferson (2008) agree with this ethos and recommend helping the mother to meet her baby immediately after birth, when their baby is still soft and warm, as this time cannot be recaptured later, if a parent is given the decision, declines, and then changes their mind later.

2.4.2 Emotional Support

Emotional support should include the gaining of trust, empathy, and attentiveness and should be displayed in both verbal and non-verbal manners (Säflund, 2004). Parents often mention the importance of feeling cared for, respected, and the healthcare workers being fully present with each interaction (NPEU, 2014; Shelkowitz *et al.*, 2015). The most common complaints from parents are about lack of sensitivity or kindness (Lasker & Toedter, 1994; NPEU, 2014). Up to 50% of parents do not feel listened to, and up to 20% of parents have feelings of distrust and lack of confidence in the staff caring for them (NPEU, 2014). Some examples of behaviours and actions that can have a negative impact are the use of euphemisms; negative body language; detached attitude; ritualisation of guidelines; paternalistic decision making and reassurances that they can have another baby (Ellis *et al.*, 2016). Although intrinsic support appears to be present, with 80% of parents, in the above-mentioned Dutch study, satisfied with that particular level of care received, also highlighted was the lack of emotional support with an astonishing 52% of parents reporting that emotional care was lacking (Gijzen *et al.*, 2016). These statistics are not surprising considering the findings of other studies discussing emotional support. In a 2010 Hong Kong study, health care professionals were less aware of the psychological impact of miscarriage than the parents in the study (Wing Shan Kong, 2010). Lee (2012) found that distress was caused by midwives focusing on clinical, rather than personal, care. In fact, one mother in Lee's study said: "She had no emotion and basically said this happens all the time..." (Lee, 2012, pp.66).

An example of what not to say came from a personal account from a mother in an Irish study about parent's experiences of care following a second-trimester miscarriage. This lady recalls the staff referring to the medication, used to induce labour, as "the termination" or "the abortion pill" (Cullen *et al.*, 2017). This is only one example. Another participant from the same study was angered and distressed when a midwife referred to putting a baby ‘in the fridge.' The Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death (2016) emphasize the importance of empathy

and many studies re-iterate this (Asplin *et al.*, 2012; Fenwick *et al.*, 2007; Meyer *et al.*, 2006; Rowlands & Lee, 2010; Säflund *et al.*, 2004). Sensitivity, and empathy, shown by staff, can make a long-lasting, positive, impression on bereaved parents (Cullen *et al.*, 2017; Kong *et al.*, 2010; Lasker & Toedter, 1994; Peters *et al.*, 2015). A lack of adequate training for staff can act as a barrier to the compassionate care that these women need (Williams *et al.*, 2008).

2.4.3 Intrinsic Support

Intrinsic support is the delivery of tangible assistance, such as memory making and physical care to the mother (McCreight, 2008). Tests need to be run, the mother needs to be kept pain free, and the routine postnatal checks need to be completed, including breast, perineal and wound care (McGuiness *et al.*, 2014b). This aspect of care can be overlooked by some midwives (McCreight, 2008; McGuiness *et al.*, 2014a). In fact, up to 1/3 of women are not given information about the management of breast milk production (NPEU, 2014). Postnatal referrals are also of great importance. Public health nurses, and GP's need to be contacted directly. A large percentage of bereaved mothers do not receive their 4-8 week postnatal GP checks, compared to the general public (NPEU, 2014). Parent's state that this GP visit was not offered. It is a possibility that this information was relayed, but not taken in, by the parents'. Therefore, a more efficient pathway could be implemented to ensure that the mother's physical needs are met, once they return home. Also, the 4-8 week postnatal checks can be a suitable opportunity for the GP to assess the mother's psychological well-being.

Assisting the parents in the making of precious memories can be seen as emotional, informational and intrinsic support, given the profound implications it has on the bereavement experience and the grieving process. In fact, the act of mothers' sharing their memories was associated with fewer PTSD symptoms, according to one London study (Crawley *et al.*, 2013). Besides holding the baby, the midwife can discuss with and assist parents in taking hand and foot prints and locks of hair; organising, and even taking, photographs; going through the memory box and/or going to the mortuary or chapel with the parents (Crawley *et al.*, 2013; Koopmens *et al.*, 2013). Some parents feel a strong desire to bath and dress the baby themselves; therefore they should be given this one opportunity (Downe *et al.*, 2015; Säflund *et al.*, 2004). Fathers appreciate tokens of remembrance, and many fathers would encourage staff to secure these tokens, even if parents decline them at the time (Samuelsson *et al.*, 2001). Lee (2012) found, in their study on pregnancy loss experiences, that parents valued the availability of good quality photographs, handprints, foot prints and locks of hair, at a later date if they were initially declined. Not making full use of the opportunities available to them to make as many memories as possible can be a cause of great regret to parents (Kelley & Trinidad, 2012; Lasker &Toedter, 1994; Lee, 2012; Samuelsson *et al.*, 2001). As memories are all that parents' can take away with them, midwives have an essential responsibility in assisting parents in making the most of this limited time to create these memories.

2.5 Impact of Being ‘With Woman'

As mentioned in the report introduction, the core midwifery values are ‘Care’, ‘Commitment’ and ‘Compassion’. When a midwife discusses her role, a sense of vocation is referred to, and some say that being a midwife is the person you are – not the job you do. Therefore, if a midwife has to compromise her quality of care to her client's, this can cause anguish and low morale (Hospice Friendly Hospitals Programme (HFHP), 2005; Hunter & Warren, 2014). Midwives face many challenges, such as shift work; increasing workloads; and traumatic childbirth events; as well as perinatal bereavement (Hunter & Warren, 2014; Jordan & Farley, 2013; Mollart *et al.*, 2013). In fact,

midwives are more likely to report work-related stress than any other healthcare professionals (Cumberlege, 2016, cited in Pezaro *et al.*, 2017). Midwife attrition in Ireland is a growing problem and causes a vicious circle of more increased workloads, and more midwife attrition and emigration. The latest statistics show that there are 3171 less nurse and midwives, working in the public health sector, in Ireland, compared to ten years ago, which is an 8% reduction (Irish Nurses and Midwives Organisation (INMO), 2017). The actual percentage is even higher, as approximately 2% of the workforce is on maternity leave, at any given time, with very little, if any, replacement (INMO, 2017). This staff retention issue is getting worse, with 78% of the 2017 internship nurses and midwives considering emigrating (INMO, 2017). In a survey compiled by the INMO (2017), 70% of these interns stated that they would consider staying in Ireland if offered an employment contract. However, only 30% had been offered one, by the HSE, at the time of the survey, in March 2017. While the HSE were spending over €8million, in just the first ten weeks of this year, on agency staff, overseas recruitment agencies were approaching the interns, with at least 70% already approached, in the same period. In the meantime, midwives in Ireland are missing breaks, risking making errors, being bogged down by paperwork and working with stressed colleagues (Hunter & Warren, 2014).

These workplace conditions are leading to a high percentage of midwives suffering emotional exhaustion; perceiving themselves as having low personal accomplishments and having symptoms of burnout and depression (Creedy *et al.*, 2017; Mollart *et al.*, 2013; Sheen *et al.*, 2015). The statistics are quite astonishing. 60.7% of midwives in one sample reported emotional exhaustion (Mollart *et al.*, 2013). 17.3% of another, large, study reported moderate to extreme levels of depression; 20.4% reported moderate to extreme anxiety, and 22.1% reported stress symptoms (Creedy *et al.*, 2017). One study determined a relationship between occupational stress among midwives and severe dysmenorrhoea (Kordi *et al.*, 2013). Secondary traumatic stress in midwifery is also an issue, causing midwives and other healthcare workers, who are involved in traumatic incidents, to be referred to as "second victims" (Schrøder *et al.*, 2017). Traumatic stress can affect the sufferer's relationships with family and friends and can include symptoms such as mood swings, irritability, and loss of confidence (NICE, 2005). Even with the current patient safety culture, which aims to encourage blame-free attitudes and approaches to errors, healthcare workers continue to struggle with issues of self-blame and guilt, even without fault (Halperin *et al.*, 2011; Schrøder *et al.*, 2017; Scott *et al.*, 2009). There is a constant battle of balance between being ‘with woman', which involves opening oneself up to the woman, her needs, and her preferences, and maintaining professional boundaries (Leinweber & Rowe, 2008). Blurring these boundaries can open midwives up to high levels of workplace stress (Abbentroth & Flannery, 2006).

Internationally, a significant amount of research has been conducted on burnout within the midwifery sector. This is possibly due to the differences in burnout levels, depending on country, and midwifery model, the midwives work in. Burnout is characterised by symptoms of emotional and physical fatigue and is as a result of chronic stress (Creedy *et al.*, 2017). To the authors’ knowledge, there is no Irish study determining burnout levels among midwives. However, of the International studies examined the rates of burnout range from 20-64.9% of midwives reporting some level of burnout, with the highest level reported in Australia (Hildingson *et al.*, 2013; Sandal, 1997; Sheen *et al.*, 2015; Yoshida & Sandal, 2013). Not surprisingly, Sheen *et al* (2015) identified a relationship between midwives who reported trauma symptoms and those who reported high levels of burnout symptoms. Understandably, one must be cautious of the limitations of studies which discuss mental health issues. On the one hand, midwives experiencing these symptoms may not wish to participate, under-estimating the true extent of these conditions. On the other hand, midwives

experiencing these symptoms may be more interested in completing these surveys and questionnaires. There is some discrepancy regarding the impact of shift work, hours worked and workload, on burnout. For example, Mollart *et al.* (2013) claim that midwives who work night shifts only are the least effective at dealing with clients' problems, whereas Henrikson & Lukasse's (2016) study found that these factors contributed very little to burnout. Hospital-based midwives are more prone to burnout, compared to community-based, or caseload, midwives, (Newton *et al.*, 2014; Yoshida & Sandall, 2013). There are a few reasons for this. Firstly, hospital-based midwives are more likely to suffer bullying, harassment or abuse from medical and midwifery colleagues (Banovcinova & Baskova, 2014; Hunter *et al.*, 2014; Yoshida & Sandall, 2013). Also, hospital-based midwives experience lower autonomy, role conflicts and an imbalance between workload and staffing levels (Hunter & Warren, 2014; Yoshida & Sandall, 2013). One review of the literature highlighted today's work culture, in hospitals, as dysfunctional and unsupportive (Sheen *et al.*, 2016).

All of the discussed implications of being part of a hospital-based midwifery workforce make it difficult to efficiently deal with continuous stress in the workplace (Mollart *et al.*, 2013). This leads to midwives having a greater fear for their registration, and of litigation (McCool *et al.*, 2009). Unfortunately, staffing levels lead to increased pressure on midwives to do more with smaller resources, resulting in insufficient support systems for midwives suffering psychologically, as a result of work pressures, or preventing psychological symptoms in the first place (Schrøder *et al.,* 2017). The offering of support from senior midwives can empower midwives, and students, whereas a lack of support, after an adverse incident, specifically, can leave midwives feeling alone, abandoned, and more traumatised (Halperin *et al.*, 2011). Ignoring the importance of organisational support is short-sighted, considering the impact burnout has on job satisfaction, and therefore attrition levels and absenteeism. (Borritz *et al.*, 2006; Yoshida & Sandall, 2015). One study's results show 13.9 sick days per annum, in the highest work burnout quartile, compared to 6.0 days in the lowest (Borritz *et al.*, 2006). The building of resilience is imperative and could be fostered through the education of self-awareness and protective self-care (Hunter & Warren, 2014). Resilient midwives could, in turn, contribute to the resilience of junior colleagues and students (Hunter *et al.*, 2014). Despite the negative experiences midwives have to face, they continue the desire to provide good quality, compassionate care (McNamara *et al.*, 2017).

2.6 Impact of Perinatal Loss on Midwives

While it is the doctors who communicate the diagnosis of a fetal demise to parents', the reality is that the parents' tend to approach ward staff for elaboration and clarification, rarely being able to differentiate between different staff roles, and often catch less experienced staff off guard (HFHP, 2005). There is a largely positive and empowering aspect of caring for bereaved parents. Being in the position to make a difference allows midwives to feel privileged to be part of such a unique life journey (Fenwick *et al.*, 2007; Keene *et al.*, 2010). Fenwick (2007) eloquently described the experiences of a group of Australian midwives, as they recounted making strong connections with families, and the positive feelings they experienced whilst creating a supportive, safe environment. Midwives acknowledged the uniqueness of every woman's experience and treasured providing care which was positive, accommodating and flexible, as well as facilitating an environment to create special memories (Fenwick *et al.*, 2007). A smaller Canadian study of six obstetric nurses, from different cultures, illuminated and confirmed these findings, with midwives touching upon their feelings of growth and transformation (Jonas-Simpson *et al.*, 2013). These studies were limited by size, but both studies demonstrate a reasonable standard of qualitative insight into the rewarding attitudes to providing bereavement care.

On the other hand, bereavement can cause midwives to have physical symptoms such as muscle tension, palpitations, stomach pain, headaches, and pressure, as well as the emotional feelings of profound sadness and self-doubt (Halperin *et al.*, 2011; McNamara *et al.*, 2017; Puia *et al.*, 2013). The physical symptoms are not surprising, given the mind-body connection. The words "a big black hole" was used to describe one obstetric nurse's feelings in Jonas-Simpson, *et al.'s* study (2013, pp.4). Not knowing what to say is a worry most midwives share (Fenwick *et al.*, 2007). When a baby dies, unexpectedly, during labour, the impact on midwives is even more substantial (McNamara *et al.*, 2017). Feelings of guilt and personal failure can lead midwives to question their self-worth (Halperin *et al.*, 2011; McCool *et al.*, 2009; McNamara *et al.*, 2017; Wallbank & Roberston, 2013). In the short term, feelings of inadequacy reduce the efficacy of midwives who are trying to manage these difficult situations (Gandino *et al.*, 2017). The struggle to carry on, and remain professional, in the immediate aftermath of a death can be an extreme challenge for a lot of midwives (Sheen *et al.*, 2016; Fenwick *et al.*, 2007).

The long-term implications of exposure to bereavement can be extensive, with healthcare workers, exposed to perinatal loss, showing higher levels of PTSD and depression compared to those who had not (Ben-Ezra *et al.*, 2014). The more highly empathic the midwife is, the greater the risk of PTS symptoms (Sheen *et al.*, 2015). Some midwives increase their alcohol intake or excessive exercise or use other maladaptive coping strategies, such as detachment, intrusion or avoidance (Măirean, 2016; McNamara *et al.,* 2017; Wallbank, 2010). Debriefing and individual staff support are recommended by HFHP (2005) but are not regularly implemented by maternity units. Counselling services are usually available to staff but people may not be aware of this service or may not want to use it, due to worries of confidentiality (HFHP, 2005). The risk of burnout increases and some healthcare workers consider taking a break from or leaving, the profession (McCool *et al.,* 2009; Sheen *et al.*, 2015; Shorey *et al.*, 2017). Repeatedly featured in the literature is the notion that midwives never forget these experiences and they change their lives forever (Jonas-Simpson *et al.*, 2013; Puia *et al.*, 2013). However, even more commonly featured, is the overall conclusion that bereavement training is inadequate and sparse, and midwives do not feel prepared for this aspect of their job, upon qualification (Chan *et al.*, 2005; Ellis *et al.*, 2016; Gandino *et al.*, 2017; Gardiner *et al.*, 2016; Gardner, 1999; HFHP, 2005; Wool, 2013). Although recommendations for improvement of bereavement training have been made for many years now, the midwifery curriculum appears very slow to change. In fact, Stratton & Lloyd (2008) describes the training for health professionals, in relation to care following a miscarriage, as one of the most neglected areas of healthcare education, and suggest that regular instruction on the meaning of miscarriage and the grief that follows, will empower and inform staff to provide more empathic and supportive care. Furthermore, certain studies showed that only 28% to 39% of midwives received any form of bereavement course, after completion of their training (Chan *et al.*, 2005; 2008). Health professionals, themselves, have highlighted the need for further education in this area (Chan & Arthur, 2009). This support and supervision, for staff working with bereaved parents, has also been recommended to promote the psychological well-being of staff and improve patient care (RCOG, 2010; Wallbank & Robertson, 2013).

2.7 Being a Student Midwife

Student midwives often find that the realities of the programme demands are harder than expected (Green & Baird, 2009). Students can face multiple stressors, such as financial pressures, juggling family, work, and college; insufficient time to study; and for some, the role change from expert nurse to novice midwife (Raisler *et al.*, 2003). This can create anxiety and tension (Green & Baird, 2009). This strain is amplified as they attempt to understand and tolerate the limits to their new, helping

roles (Coldridge & Davies, 2017). A student's learning ability can be impeded when they are worried, anxious, or de-motivated (Power & Farmer, 2017). Students often feel closer to, and more in tune with, the women in their care, than the qualified midwives looking after them, and therefore find themselves frustrated by their restrictions, in their perceived advocacy role (Coldridge & Davies, 2017). The busier the hospital unit is, the more students express feelings of being lost, invisible and powerless (Coldridge & Davies, 2017). Compassion fatigue and burnout are not isolated to the more experienced midwife. Continuous exposure to distressing situations can increase student midwives susceptibility to developing these mental health issues (Abendorth & Flannery, 2006). A study by Beaumont *et al.* (2016) reported that over half of their sample of student midwives' suffers burnout, with 40% reporting compassion fatigue. The student midwives were also found to be at higher risk for self-judgement, leading to reduced compassion towards themselves and others (Beaumont *et al.*, 2016). Some of these findings may be due to an apparent theory – practice gap (Jordan & Farley, 2008; McKenna & Rolls, 2011). As the role of the midwife encompasses being an expert in the normal physiological process, the midwifery curriculum begins with a focus on normal birth. However, most students experience traumatic births and perinatal bereavements early in their training (McKenna & Rolls, 2011). The stress of witnessing these events, for which they are not prepared, can affect student's confidence in performing day-to-day tasks; cause feelings of doubt in their role in emergency situations; and can be a factor in their decision to leave the profession (Davies & Coldridge, 2015; Green & Baird, 2009). They are identified as potentially needing extra investment in support and nurturing, by experienced midwives (Hunter & Warren, 2014).

Preceptors (mentors) can have a definite impact on student's clinical experience, with students feeling 'lucky' or 'unlucky' with the preceptor they are assigned (Hughes & Fraser, 2011). Preceptors are central to the development of a student's competence in practice, especially about student's confidence and self-esteem (Hughes & Fraser, 2011). Having a therapeutic presence of a preceptor positively predicts students' self-efficacy (Jordan & Farley, 2008). A preceptor should be approachable; instil confidence; be an advocate for women and be an evidence-based, reflective practitioner (Hughes & Fraser, 2011). Students were recognised, by Frazer *et al.* (2014), as needing staff support, positive learning environments and opportunities for reflection, in the clinical setting, to facilitate their clinical learning. Some preceptors can be controlling, can make student midwives feel undermined and can reduce their confidence (Hughes & Fraser, 2011).

2.8 Psychological Impact of Bereavement on Student Midwives

Student midwives encounter bereaved parents, at their most vulnerable time, as they attempt to come to terms with the diagnosis of, and give meaning to, their child's death (Kelley & Trindad, 2012). The student's emotional responses are not unlike that of qualified midwives. Various feelings are described by students, such as helplessness, inadequacy, shock, and a universal need to cry (Begley, 2003; McKenna & Rolls, 2011). This distress makes them vulnerable to unresolved grief, which is associated with increased burnout (Begley, 2003). Continuous exposure, coupled with a student's lack of control, could lead to a constant re-traumatisation and increase the risk of burnout, depersonalisation and compassion fatigue (Abentroth & Flannery, 2006). Other studies have reported on student midwives feelings of diminished confidence to communicate effectively, and on their limited competence to provide adequate care to bereaved parentst (Begley, 2003; Rondinelli *et al.*, 2005). The lack of confidence creates a barrier to developing a trusting and fruitful relationship with the bereaved parents (Alghamdi & Jarrett, 2016). The students' feeling of awkwardness, which is transmitted, to the mother, is likely to be interpreted as something else, such as disapproval, judgment or ambivalence (Rådestad *et al.*, 2014). Many students are uncertain as to the appropriateness of displaying raw emotion and often feel the need to 'hold it in' until they are on

their own (McKenna & Rolls, 2011). Again, like midwives, not knowing what to say is foremost in student's minds when thinking about caring for grief-stricken parents (Mitchell, 2004). Some students feel that they are left to deal with their emotions by themselves, rather than being nurtured and feeling valued (Wallbank & Robertson, 2013). Lack of clinical exposure has repeatedly featured in the literature (Alghamdi & Jarrett, 2016; Begley, 2003; Coldridge & Davies, 2017; McKenna & Rolls, 2011). Many students recall being discouraged by preceptors or clinical superiors (Alghamdi & Jarrett, 2016). There is a suggestion that the midwives, themselves, feel unprepared and vulnerable, and having a student with them, taking in everything they say, would reduce their confidence more. Some students, when offered exposure, feel uncertain about their role and therefore distract themselves with routine physical care: doing, rather than being (Alghamdi & Jarrett, 2016; Begley, 2003).

Training in the area of bereavement and personal coping is found to be inconsistent at best, as attested by the vast majority of studies, discussed in this literature review (Alghamdi & Jarrett, 2016; Begley, 2003; Gold, 2007; McKenna & Rolls, 2011, Mitchell, 2004). In a survey, by Kalu (2016), who developed the questionnaire used in this study, it was reported that only 33.2% of midwives have adequate bereavement support knowledge and just 18.7% reported having bereavement support skills. Kalu confirmed the need for regular bereavement study days, and the importance of emotional, as well as practical, support for midwives delivering bereavement care. Inadequate training may cause students to suffer psychological trauma, resulting in mental health complications (Begley, 2003). Although students are aware of the professional support offered to them through their clinical setting, and their university, including counselling, very few, if any, seek assistance through these avenues (McKenna & Rolls, 2011). Most students find support from classmates, friends, and family (McKenna & Rolls, 2011). The problem with this is that these people may not be equipped to provide the type of support needed (Halperin *et al.*, 2011; McKenna & Rolls, 2011). Some students are left requiring nearly as much support as the bereaved families (Begley, 2003).

2.9 Existing Education Strategies

> *"The foundation for quality services lies in having a competent midwifery workforce... The key to a competent workforce is education"*
>
> WHO (2014, pp. 4)

Education has a significant, direct, impact on bereavement care provision, and in turn, psychological outcomes for healthcare workers and parents (Ellis *et al.*, 2016; Rogers *et al.*, 2008; WHO, 2014; Wool, 2013). Literature suggests a correlation between a lack of information and knowledge on bereavement, and the healthcare worker's sense of inadequacy and helplessness (Gandino *et al.*, 2017). Given the demand on midwives for providing evidence-based care, it is essential to find ways of making training efficient, intellectually rigorous, and well integrated into clinical practice (Raisler *et al.*, 2003). Educators need to also bear in mind that the learning styles of students differ from each other, and that student's information processing and instructional preferences change and evolve throughout their training (Andreou *et al.*, 2014; Mitchell *et al*., 2015). Many different approaches are used to change and improve practice, all claiming to be effective (Grol and Grimshaw, 2003; Rogers *et al*., 2008). No method is superior for all situations, and they are all effective in some way (Breytenbach *et al.*, 2017). We probably need them all, at some point, and they all need to be continuously monitored for their effectiveness (Grol & Grimshaw, 2003; Rogers *et al.*, 2008). A report developed from the 'What Works? Student Retention & Success Programme' (Thomas, 2012), in the UK, suggests that the academic programmes which have the best success make use of a variety of teaching strategies, including group activities and real-world learning. Young & Randall (2014) came up with similar recommendations, after evaluating a blended learning module, with 2nd-year midwifery students,

using an electronic package, case presentations, and simulations. Based on the findings of the study, the authors suggested improved reflective skills, clinical reasoning skills and a bridge in the gap between theory and practice.

It is also suggested that to ensure the credibility of any education programme; it is essential to have educators, who are experts in their fields (Mancini, 2011). The importance of having a competent educator, who is also a competent midwife, is re-iterated by WHO (2014), in their publication 'Midwifery Educator Core Competencies.' This document was published, mainly, to guide midwifery faculty, but it can be assumed that the message should be the same for anyone attempting to educate students on any midwifery related topic. Some vital messages were incorporated into this document. The most important messages are to maintain clinical practice; to act as a role model; to demonstrate and value their own lifelong learning and to apply research findings to their own clinical practice. When it comes to educating students, WHO state that midwife educators need to be confident in the areas of presentation and argument and must communicate professionally and effectively. Also, the educator should have knowledge of theories of adult learning and be competent in the use of a variety of competency–based teaching methods. And finally, the educator is required to have a solid foundation in organising, implementing and evaluating the effectiveness of the education program in question. Collaborating with other professionals, and utilising assessment and evaluation data, to enhance the teaching – learning process is also essential (WHO, 2014).

Some institutions have implemented different bereavement education strategies, and have evaluated their strengths and limitations:

One full day is devoted to bereavement, in one UK University (Mitchell, 2004). The day includes: an exploration of feelings surrounding loss, including grief theories; the diversity of grief reactions; a video, detailing one family's experience of neonatal death; evidence-based interventions for helping bereaved parents; discussions on supportive coping strategies, such as counselling and debriefing; and a visit from a member of SANDS, recounting personal experiences. Upon evaluation, the students commented that some of their fears and worries had been relieved to a certain extent and that the day was handled sensitively. However, the theoretical input was not commented on. The discussion sessions were appreciated the most by the students, especially the input from the speaker from SANDS, which they claim helped them to gain empathy. It was suggested that didactic approaches are rarely the appropriate approach to learning the skills and attitude required for bereavement care (Mitchell, 2004).

More recently, a collaboration of University staff, around the UK, was formed, to design 'An interactive workbook to shape bereavement care for midwives in clinical practice' (Hollins Martin *et al*., 2014). A scored survey instrument called the Understanding Bereavement Evaluation Tool (UBET) was purposely designed to evaluate students' knowledge pre and post workbook. The workbook itself was extensive and included content such as definitions; procedures; models of grieving; difficulties adjusting to loss; ongoing support; staff support; assessment of spiritual needs; and encouraging memories. The workbook was evaluated as effective to underpin the theoretical knowledge and clinical skills needed to provide bereavement care. However, it was suggested that it lacked group work and interaction, which was considered necessary (Hollins Martin *et al.*, 2014). Also, some participants questioned the appropriateness of completing the workbook in the classroom environment, due to the sensitive nature of the content, as they were asked to write about a personal encounter with a loss. As it was a workbook and no interaction was required, it

was thought, by some, that it could have been completed in the comfort and privacy of their own home (Hollins Martin *et al.*, 2014).

The use of literature to promote the emotional intelligence of midwifery students can make for a very positive and rewarding learning experience. The poem ‘Elegy for a Stillborn Child,' by Seamus Heaney, draws the reader into the emotions of the couple, from the perspective of the father's close friend. Patterson *et al.* (2016) chose to use this poem, as a group discussion tool, with a group of midwifery students', who evaluated the remarkable poem as effective as an education tool and recommended this form of teaching. It created a lot of discussion as to the different meanings of Heaney's powerful words. The rawness of the narrative creates a stark, disquieting image of loss and encapsulates a wealth of insight into the devastation that stillbirth can cause. Poetry is also used in the wider nursing cohort. Healy and Smyth (2017) also evaluated a poem, as an education strategy, to challenge attitudes toward elderly patients. The students considered this deeper approach to their learning as valuable to critically analyse issues, such as task centred care versus person-centred care. It was evident, from this evaluation, that poetry, in a large group format, is a worth-while engagement strategy for students, to increase their critical and creative thinking. There needs to be flexibility in student's thinking for critical and creative skills, which will contribute to decision making, to be developed (Healy & Smyth, 2017).

A collaborative art project was more recently used as a method to explore perinatal death, in a regional maternity hospital in Ireland (Barry *et al.*, 2017). Although the sample size was small, with just 6 post registration students, the data gathered from the in-depth semi-structured interviews was efficacious. The students attended the Amulet artwork exhibition, which allowed them to enter into the woman's world and allowed them to ‘hear her pain.' Exposure to, and reflection on, the exhibition increased the student's awareness of the non-linear nature of the grieving process (Barry *et al.*, 2017)

IMPROVE (Improving Perinatal Mortality Review and Outcomes Via Education) is a programme developed by Gardiner et al (2016), for a half day workshop, for a variety of healthcare and medical personnel. Six teaching stations were set up during a one-day programme: 1. Autopsy consent; 2. Autopsy and placental examination; 3. Investigation of perinatal death; 4. Examination of the baby; Perinatal mortality classification; 6. Psychological and social aspects of bereavement. 30 minutes was spent at each station. Gardiner used an approach to teaching called SCORPIO (Structured, Clinical, Referenced, Problem-orientated, Integrated and Organised). SCORPIO is a medium for skills training, for small groups of multi-professional participants. The post-programme questionnaire showed that knowledge and confidence were significantly increased for each station. A lot of the content of this programme was geared towards the neonatologists and pathologists, rather than the midwives and neonatal nurses. However, lessons could be learned from this rotating structure, which kept the participants in this study engaged. The confidence and knowledge, after completion of the workshop, was similar among doctors and midwives, even though the confidence levels were higher for doctors before the programme (Gardiner *et al.*, 2016). The participants enjoyed the rotation of small, inter-disciplinary groups, giving them opportunities to form discussions. It was felt that adding an extra 10-15minutes per station would have been beneficial. Many participants were particularly appreciative of station 2, as most were previously unaware of the autopsy process. Prior to the workshop, midwives reported lower confidence in talking with parents about autopsy. This learning gave them the confidence needed to discuss this process with affected parents. Equally, participants valued the information about the additional and alternative investigations. It would be interesting to evaluate the participants' knowledge at a later date, as well as immediately after the programme.

Neonatal nurses have similar requirements to midwives, regarding education in the caring of families of dying infants. One Neonatal Intensive Care Unit (NICU) created an educational intervention, and pre and post education knowledge was assessed, using an instrument called "Comfort for Dying Infants" (CLDI) (Rogers *et al*., 2008). The intervention, run by hospice experts, showed significantly higher levels of knowledge in the area of ethical/legal issues and symptom management, but not for spirituality/anxiety, or prevention of compassion fatigue. Interestingly, the communication/culture module scores were lower in the post-test scores, compared to pre-test scores. The findings from this study suggest staff support, and debriefing, after each infant's death (Rogers *et al*., 2008).

Meyer *et al.* (2009) evaluated a one day 'experiential learning paradigm,' called Program to Enhance Relational and Communication Skills (PERCS), focused on communication skills and relational abilities, and the feedback confirmed that it was highly valued, clinically useful and logistically feasible. Challenging conversations were chosen for the multi-disciplinary participants to re-enact. In their immediate and 5-month follow-up, respectively, 93% and 98% of the participants indicated an improvement in their sense of preparation; and their communication skills and confidence in having difficult conversations. Anxiety was reduced in 74% and 82% of the participants (Meyer *et al.*, 2009). The benefit of learning more about other disciplines was noted. The improvement of specific communication skills was noted, such as making introductions; remembering to use people's names; beginning conversations with family's concerns; listening attentively; sitting rather than standing, and recognising the value of silence.

Role-playing puts students into the role of the midwife and projects their thinking and imagination forward, in order to figure out what it will mean for the student to be responsible for the care they give (Young & Randall, 2014). A Practice Education Facilitator in a hospital in Manchester developed a contemporary simulated approach, called the Neonatal Simulated Bereavement Session (Colwell, 2017). A large percentage of the participants felt that this session enhanced their practice (Colwell, 2017). In Tobler *et al.'s* (2014) study on the effectiveness of a simulation-based workshop for doctors, 100% of the participants reported improvements in their ability to deliver bad news after the workshop. Vermeulen *et al.* (2017) also sought to explore the experiences of final year student midwives with High-fidelity perinatal simulation training and found that it increased their confidence and competence. Even though students can report a moderate to high level of stress associated with simulation, they still rate the experience as a valuable learning tool (Cantrell *et al.*, 2017). The presence of people role playing family members enhances the realism of the simulated clinical experience, allowing students to practice providing support to the greater family (Leighton & Dubas, 2009).

Some charity organisations facilitate workshops, with the intention of improving care. The IHF holds workshops on loss and bereavement, as well as self-care (IHF, 2017). One of the workshops is entitled 'Resilience – Staying well at work', which they state is important for staff to reflect on, and understand, the potential impact this work has on them. Another workshop is entitled 'Children and Loss,' and aims to explore the impact of loss through death and illness on children. Whilst these workshops can be beneficial, the IHF did not, until mid-2017, hold any workshops pertaining to perinatal death. They have just held their first workshop entitled 'Dealing with Loss (Maternity Setting)' (IHF, 2017). This covers the National standards; the impact of loss; the grieving process; and self-care. This extensive 6.5-hour workshop appears beneficial, but must be booked as a group workshop for an average cost of approximately €50 per head which, in today's climate, unless it is paid for by the organisation a midwife works for, it does not create much motivation to attend. SANDS holds interactive, skills-based, one-day workshops for midwives, student midwives, and

multi-disciplinary teams. This workshop includes film, audio clips, discussions, presentations, reflection and group exercises. This beneficial course is said to give midwives confidence and contains relevant, up-to-date information (SANDS, 2014). Unfortunately, this course is only available in the UK. More discerningly, the workshop also costs £42 per person.

2.10 Promotion of Self-Care / Self-Compassion

> *"Self-compassion involves being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness".*
>
> (Neff, 2003, pp. 87)

The important concept in Buddist philosophy – the concept of self-compassion - is broken down eloquently by Neff (2003). Compassion entails being touched by the suffering of another person, and opening oneself to another persons' pain, without avoiding or disconnecting from it, and having feelings of kindness towards that person, and a desire to alleviate their suffering, with a non-judgemental understanding of the person who fails or does wrong (Wispe, 1991, cited in Neff, 2003, pp. 87). Self-compassion brings these same feelings inward, offering non-judgemental understanding to one's own pain, suffering, and inadequacies so that a person's own experiences can be seen as part of the larger human experience. It entails respecting oneself as being fully human – imperfect and limited and forgiving oneself for any failings. That is not to say that compassion is extended to oneself because they are superior, or more deserving than others, rather it is done because the person recognizes their interconnectedness and equality with others (Brown, 1999, cited in Neff, 2003, pp.87). This, in turn, means that Self-compassion is associated with enhanced feelings of compassion and concern for others. Moreover, having self-compassion should not imply inaction or passivity with regard to weaknesses, but rather, it means that the actions needed, for optimal health, are encouraged with gentleness and kindness (Neff, 2003).

As the evidence states, burnout and reduced self-compassion can affect midwives as early on in their career as their training, thus justifying suggestions that midwives might benefit from interventions which would increase self-compassion (Boellinghaus *et al.*, 2014). College students, in general, are often hard on themselves when they fall short of achieving their valued academic goals (Neely *et al.*, 2009). According to Neely's study (2009) of self-kindness among college students, a reliable correlation was shown between self-compassion and well-being. A reduction in self-compassion can render a midwife less capable of conveying authentic compassion towards the women in their care (Beaumont *et al.*, 2016). In a questionnaire completed by student midwives in the UK, self-kindness was found to be associated with less burnout and greater well-being (Beaumont *et al.*, 2016). On the flip side, high self-judgement scores were associated with increased burnout, less compassion for others and lower personal well-being (Beaumont *et al.*, 2016).

Having a compassionate attitude towards oneself requires mindfulness, which is a balanced state of awareness, avoiding the two extremes of over-identification and disassociation (Neff, 2003). Bishop, *et al.* (2004, cited in Boellinghaus *et al.*, 2014) agrees with Neff and argues that it also comprises an attitude of openness, curiosity, and acceptance towards any arising experience. Mindfulness allows for a non-judgemental state of mind, in which a persons' feelings and thoughts are observed for what they are, yielding a greater insight into their experience (Neff, 2003). It allows head-space and a flexible mindset, which is not attached to any particular point of view (Langer, 1999, cited in Neff, 2003, pp.88). When a person is not being mindful, they are either not accepting their painful thoughts or feelings for what they are or causing an intense emotional resistance to the pain, causing a focus on one's negative emotions. In the case of these emotions being associated with failure or inadequacies, there is an exaggerated focus on implications of self-worth, leading to

severe self-judgement and, possibly, judgment of others (Nolen-Hoeksema, 1991, cited in Neff, 2003 pp.89). According to Boellinghaus, *et al.* (2014), who performed a review of the literature on interventions to increase self-compassion, mindfulness-based interventions did show an increase in post-intervention self-compassion scores and found that participants in these studies were more able to empathise with clients. Limitations to the studies were identified. Some lacked control groups, and none of them used follow-up assessments, resulting in the inability to assess the durability of the changes in self-compassion. Nonetheless, the evidence shown, regarding the interventions as potential candidates to increase self compassion, cannot be ignored. Midwives in another study participated in an eight-week mindfulness course, once a week, including daily practice (Warriner *et al.*, 2016). Course attendance was 87% and immediate and 4-6 month post-intervention evaluations were completed. Sixty eight percent of participants reported a reduction in anxiety, as well as an increase in self-compassion and resilience by 74% and 70% respectively. Improvements in home life, work life and the culture of their workplace were also reported. Foureur *et al.* (2013) facilitated a one day workshop and provided a mindfulness CD for nurse and midwives in their study. Even though the newly learned techniques were only practices 44% of the available time, a reduction in stress levels was still seen for some participants, and improvements were seen in the general health, sense of coherence and orientation to life among the midwives.

2.11 Conclusion

This literature review outlined the devastating affect perinatal bereavement has on parents, the wider family and their social circle, as well as the midwives, and other healthcare professionals, looking after these families during this time of loss. Also highlighted are the long term psychological implications, which can alter the parents' lives forever. Midwives, who form quick and close bonds to grieving parents', are also affected by these losses, long term, and these feelings accumulate, causing burnout, and other emotional and physical symptoms over time. The lack of education in the area of bereavement care is evident, and this exacerbates midwives feelings of doubt, leading them to question themselves and their practice. A large amount of evidence has shown how insensitive and inadequate care during, and immediately after the loss of their baby, affects the parents' whole experience and can have detrimental effects on their psychological wellbeing going forward. The experience of being a student midwife was explored, and the implications exposure, and lack thereof, to bereavement situations, was highlighted as a major barrier to learning how to provide effective care. The importance of cultivating self-compassion and mindfulness was suggested as being associated with reduced burnout and increased self-kindness. Finally, teaching strategies pertaining to bereavement care provision, and midwifery and nursing in general, was explored, and their strengths and limitations discussed, in order to plan and justify an effective Bereavement Care Training & Education Workshop.

Chapter 3: Research Study

3.1 The Focus of the Research Study

In 2016, the HSE developed the 'National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death', to improve and harmonise the care of a very vulnerable group of women and their familes. These standards included a provision for better education for all staff and health care professionals working in Irish maternity care services. In response, a one-day interactive Educational Training Workshop in Bereavement Care (ETWBC) was developed for student midwives in a Dublin Maternity Hospital. This workshop was then evaluated. The research questions, the intervention design, methods used, and ethical considerations are discussed in this Chapter.

3.2 Aims of the study

1. What are the Knowledge and the Skills required by Student Midwives (4th Year Internship and Higher Diploma in Midwifery) to deliver bereavement care to parents following a pregnancy loss or perinatal death?
2. Does participation in an educational training workshop in bereavement care improve Student Midwives' knowledge and skill to deliver bereavement care to parents following a pregnancy loss or perinatal death?
3. Does participation in an educational training workshop in bereavement care improve Student Midwives' self awareness in relation to deliver bereavement care to parents following a pregnancy loss or perinatal death?
4. Does participation in an educational training workshop in bereavement care improve Student Midwives' self-compassion?
5. Is Organisational support related to Student' Midwives confidence to provide bereavement care to parents following a pregnancy loss or perinatal death?
6. What are facilitators and barriers to gaining confidence to provide bereavement care?

3.3 Ethical considerations

This research project was carried out in accordance with the 'Ethical Conduct in Research Professional Guideline' (NMBI, 2007).

3.3.1 Ethical approval:

Ethical approval was granted by the Ethics Research committee in the National Maternity Hospital. Ethical exemption was granted by the Human Research ethics Committee, in University College Dublin.

3.3.2 Informed Consent:

- A 'gate-keeper' was assigned to give the students verbal information about the study and hand out information leaflets about the study. *See Appendix 3*
- Students who were interested in participating in the study signed a 'consent to be contacted' form. *See Appendix 4*
- Signed 'consent to participate' forms were received prior to the first questionnaire being filled out. *See Appendix 5*

- For any students who were not interested in participating in the study, alternative work was available for them to complete, related to bereavement, at the time of the workshop.
- Students were reminded at regular intervals that they can withdraw from the study at any time.
- Focus group participation was voluntary, and all participants gave verbal consent to participate in the focus group and to being audio recorded. Only once verbal consent was given by all participants did the audio recording of the focus group commence.

3.3.3 Confidentiality:

Confidentiality was maintained throughout the project. Signed consent forms were locked in a cupboard in a locked office.
Codes were assigned to each participant, for the filling out of the questionnaires, and only the research assistant had a copy of the coding.
Focus group participants were made aware of the focus group, in the information leaflet, and given the option of participating. Only the students who showed an interest in participating were contacted with an invitation to attend to the focus groups. Only the research assistant and gatekeeper, who facilitated the focus groups, knew the identities of the focus group participants. Each participant was given a separate code to the ones for the questionnaires. Transcription of the focus groups was undertaken by the research assistant and any reference to someone's name, in the focus group, was replaced by the code.
Transcripts and questionnaires were stored separately to questionnaires.

3.4 Implementation of the Educational Training workshop in Bereavement Care (ETWBC)

Development Process

> *Many different educational approaches are used to change practice, all claiming to be effective. No approach is superior for all changes in all situations. We probably need them all, at some point, and they all need to be continuously monitored for their effectiveness.*
>
> (Grol and Grimshaw, 2003)

A literature review about students' bereavement education needs was compiled. From there, the priorities for the bereavement training workshop were broken down. The following key points were highlighted and referred to throughout the development process:

1. Students easily forget didactic learning approaches around grief and bereavement (Breen *et al*., 2015), and approaches around theoretical lectures fail to promote reflection on personal reactions.
2. Empathy is a key feature in bereavement care, and as such should be enhanced wherever possible (Patterson *et al*., 2016).
3. Role play and simulations are regarded as a high standard second option to experience, for exploring different communication skills and methods (Colwell, 2017; Meyer *et al*., 2009; Tobler *et al*., 2014).
4. There is a general lack of confidence in communication skills when looking after bereaved parents (Steen, 2015, Fenwick *et al*., 2007)
5. Reflective practice for students can contribute to the development of skilled, self-aware and engaged practitioners (Gallagher *et al*., 2016).

6. Given that working closely with distressed women could contribute to midwives sense of emotional distress, the well-being of the students should be prioritised throughout the training process (Ben-Ezra *et al*., 2014).
7. The making of memories can have profound positive implications for parents, and as such is a very important aspect of bereavement care (Crawley *et al*., 2013).

The evidence emerging from the literature review highlights how traditional education on perinatal bereavement continues to have a minimal and inconsistent presence in most undergraduate curricula. Whilst acknowledging the importance of a good theoretical foundation, the use of creative and innovative teaching strategies are becoming an attractive option to providing quality learning experiences for undergraduate midwifery students.

As the importance of educational interventions being facilitated by experts in their field, has been recommended, it was felt the workshop should be facilitated by the key members of the research team: The two bereavement midwives in the hospital and the lecturer in the area of grief and loss in the affiliating university, and member of the Bereavement Care Standards Development Group.

3.5 Expert Panel Feedback on Workshop

A focus group was held with a panel of midwifery and nursing management and staff from the neonatal unit, chaplaincy department, antenatal ward, as well as the Assistant Director of Midwifery. The purpose of this focus group was to discuss the proposed material of the workshop and gain feedback from these experts, as to the appropriateness of this content and the teaching strategies proposed. The content was approved and welcomed by the expert panel. The focus group was audio recorded and transcribed for future reference.

Drawing on the literature and the feedback from the expert panel, the following was included in the Educational Training workshop in Bereavement Care (ETWBC):

- A small quiz and discussion to assess students' knowledge to date:

This quiz was completed on the 'Soctrative' app, and students were given fun pseudonyms, to protect their identity, as the answers appeared on the screen, in real time. The answers were then discussed as a group.

- Supporting bereaved parents – What to say and do:

Verbal and non-verbal communication was examined in this section of the workshop, as well as the use of analogies to describe grief, to increase empathy and understanding. Advice was given about what not to say to a bereaved family member. The video called 'A Letter to My Doctor' was played. It was developed made by a bereaved mother, and includes advice from her perspective and photographs of babies who had passed away, provided by their parents.

- Making memories:

Different services that are available to bereaved parents, through the hospital and through charity organisations, were outlined. The contents of the new Feileacain memory boxes were displayed for the students. Different ways of making positive memories were discussed, such as photographs, bathing and dressing the baby, as well as helpful books and resources, and other ways to help to communicate the loss to siblings and other family members.

- ‘Elegy for a Stillborn Child’

This poem captures the varied perspectives of loss and was previously shown to be an evocative stimulus for group engagement in the classroom. The poem was chosen to increase empathy / emotional intelligence, and create discussion around different perspectives of grief. This was presented and discussed as a group, in an informal manner.

- Role Play

The students were divided into 3 groups, with 6-7 students in each group. The workshop facilitators asked 2 students to volunteer to participate in each group.
One antenatal scenario of a woman being admitted for induction, with a mid trimester loss, was set up, at one end of the room. The bereavement midwife/facilitator posed as the grieving mother in this scenario.
One postnatal scenario of a mother with her stillborn baby was set up at the other end of the room. The other bereavement midwife/facilitator posed as the grieving mother in this scenario. One student in each group participated in the role-play, as the midwife looking after the woman. A scenario, based on true events, was read out to each participant, giving clinical details of the mother, as well as her demographic details and obstetric history. The student was asked to proceed in providing physical and emotional care to the ‘mother’. Leaflets were available for the student to utilise. The observing students were asked to write down there thoughts on what the students did right and what could have been done differently. Verbal and no-verbal communication could be commented on.
In another room, a cuddle cot demonstration was set up, and facilitated by the Clinical Placement Co-ordinator, for the BSc students, and the Clinical Tutor, for the Higher Diploma students. The students were shown how to set up the cuddle cot and took turns practising this. Each of the 3 groups had the opportunity to take part at all 3 stations. Each scenario lasted 15 minutes each. The research assistant acted as time-keeper for these scenarios. Once this was completed, a group discussion allowed the students to reflect on the role plays – what they did right, what they could have done differently, and how they felt.

- Reflective Diary

The students were given the opportunity to reflect on positive aspects of their life that can help them when they have a negative experience during their working day, or indeed, their personal life. A notebook was given to the students to use as a reflective diary, so that work situations can be reflected on.

- Self Care and Mindfulness

This involved a short power-point presentation on the importance of self care, and then the students commenced a style of meditation called a ‘Body Scan’. The students were given blankets and the opportunity of lying down or remaining seated in a comfortable position. The facilitators ensured the room was warm enough, lights were turned off and a ‘Do Not Disturb’ sign was placed on the door, to reduce distractions. The meditation itself lasted 45minutes.

- Discussion and debriefing

The students were given tea/coffee, and biscuits and a circle was formed with the chairs for some informal wind-down time. The facilitators ensured that the students’ emotions were stable, gave an opportunity for questions, and handed out small purple mesh bags, with designs of butterflies, filled

with chocolate, as a symbol of self-care promotion. The facilitators also re-iterated the importance of the students looking after themselves that evening but also going forward in their careers.

3.6 Setting / Timing / Logistics

The workshop for the BSc Midwifery students was held in March, 2017. This workshop took place in the classroom / clinical skills of the education centre of the hospital. This room includes beds, cots, BP monitors and other equipment. The workshop for the Higher Diploma Midwifery students was held in May, 2017. Due to scheduling conflicts for the classroom, this workshop was set up in a large sitting room / informal meeting room in the hospital. This room has no equipment in it, so beds were formed out of couches, and blankets, cots, divider screens and BP monitors were borrowed from wards and equipment rooms.

Both rooms were set up nearly identically, with a table set up at the front of the room, displaying the memory box and contents, teddy-bears, many lit candles, over a purple mesh tablecloth. Another table displayed information leaflets and books. The sitting-room had lots of couches and armchairs for the students to sit on, and all chairs were placed in a semi-circle facing the front of the room. The students were asked, in advance, to arrive in comfortable clothing.

Table 1: Timetable of Workshop

Time	Topic	Facilitators
08.00 -08.20	**Welcome and introduction**	**Bereavement specialist 1&2**
08.20 -08.50	**Bereavement in Midwifery** Quiz using Socrative app	**Bereavement specialist 2**
08.50-09.30	**Supporting bereaved parents; what do I say and do?** Video- one pink balloon	**Bereavement specialist 1**
09.30-10.00	**Coffee**	
10.00-10.20	**Making memories**	**Bereavement specialist 2**
10.20-10.50	**Elegy for a stillborn child**	**Bereavement specialist 1**
10.50-1100	**Explain role plays & divide into groups**	**Bereavement specialist 1 & 2**
11.00-12.30	**Role play: 15 mins per role play**	
11.00-11.15	Role play 1 (Stillbirth) Repeated 3 times, in Midwives sitting room	**Bereavement specialist 1** **R.A. observing & note taking**
11.15-11.30	Role play 2 (2nd trimester miscarriage) Repeated 3 times, in Midwives sitting room	**Bereavement specialist 2** **UCD expert observing & note taking**
11.30-11.45	Cuddle cot demonstration Repeated 3 times, in equipment room	**Clinical tutor**
11.45-12.20	Feedback from role plays	**All**
12.20-13.00	**Lunch**	
13.00-13.30	**Reflective diary**	**UCD expert**
13.30-14.30	**Self care and Mindfulness**	**UCD expert**
14.30-1500	**Discussion & debriefing**	**All**

3.7 Research Design

A Sequential Longitudinal Mixed Method Design was used in this study.

To evaluate the ETWBC, 2 questionnaires were completed by the participants at 3 time points; pre and post completion of the intervention and at 3 month follow-up [Outcome Evaluation]. Qualitative information was also collected to evaluate the experience for students of participating in the workshop using a focus group (n=12 Midwifery Students) [Process Evaluation].

3.7.1 Outcome Evaluation: Questionnaires

Primary Outcome: Confidence [measured at all 3 time points; pre Educational Workshop, post Educational Workshop and at 3-months follow-up]

Secondary Outcomes: Self-awareness, Organisational support, Self-Compassion [measured at all 3 time points; pre Educational Workshop, post Educational Workshop and at 3-months follow-up]

3.7.2 The Process Evaluation: Focus Groups

A Focus group (n=6 each) was held with consenting members of each group of students (4th year Midwifery and 1st year Higher Diploma Midwifery Students) within 10 days of completing the ETWBC. The aim of the focus group was to gain an understanding of the students' experiences of participating in the Educational Training Workshop and to support the outcome evaluation of the study. The focus groups were facilitated by the Research Assistant and a member of the Research Team who was not involved in facilitating the workshops. The Focus group discussion was audio recorded and the data transcribed.

3.8 Rationale for Using the Above Research Methods

Mixed methods research is an integration of a quantitative design, which means that the data discussed are numbers, and a qualitative design, which means that the data discussed are words (Fawcett, 2015). The quantitative data was important to capture numerical data on the students' knowledge, skills, and perceptions. Both the quantitative and qualitative data were integrated to add depth and clarification to the results. The advantage of using a mixed-methods approach is that the goal to capture the students' perceptions of their experience was achieved.

Focus groups and interviews are the most common research methods in healthcare research, with focus groups being used to generate information on collective views and the meanings behind these views (Gill *et al.*, 2008). The researchers chose to hold 2 focus groups – one for each class, for 2 reasons. Firstly, it was felt that the pre-existing groups have shared experiences and can enjoy the comfort of familiarity, facilitating the discussion and allowing them to challenge each other comfortably. Secondly, by holding 2 focus groups, the researchers would be able to identify themes which emerge from both groups, strengthening these particular themes. Interesting discussion can then arise when themes differ between groups. The themes identified, within the data, captured important elements relating to the research questions.

3.9 Outcome Evaluation (Quantitative Data) from Questionnaires:

3.9.1 Sample

Convenience Sampling was used to recruit participants. From a total of 19 4th year BSc Students and 24 Higher Diploma students from the National Maternity Hospital / University College Dublin, 18 and 21 students, respectively, were eligible to be included in the study. Three Higher Diploma students did not participate in the workshop: two due to recent bereavement and one due to being on maternity leave. One student from the BSc course returned the consent form but did not return all three questionnaires, and as such, was also excluded from the results.

The total final sample of participants who participated in the workshop and completed all 3 questionnaires was 38.

3.9.2 Inclusion / Exclusion Criteria

4th year BSc Midwifery students and Higher Diploma Midwifery students were included in the study.

Exclusion criteria included students who did not wish to participate; students who had recently suffered bereavement; students who were not available, due to illness or maternity leave. Data from students who did not complete all 3 questionnaires were excluded from the final results.

3.9.3 Data Collection

The questionnaires were handed out at 3 time-points: pre-workshop, post-workshop and 3 months post workshop. The students were given an addressed envelope to return the questionnaires in the internal post. They were also given the option of contacting the research assistant to collect the questionnaire from them, on their respective wards, within the hospital.

3.9.4 Data Collection Instrument

The Perinatal Bereavement Care Confidence Scale [PBCCS] (Kalu *et al.*., 2017, 2016) *See Appendix 5*. This newly designed questionnaire consists of 4 subscales namely, Bereavement Support Knowledge Scale; Bereavement Support Skills Scale; Self-Awareness Scale and Organisational Support Scale. The scales are scored using a 5 point likert scale ranging from strongly disagree to strongly agree (1-5). Good psychometric properties of all 4 PBCCS Scales are reported by Kalu *et al.* (2016) with Cronbach's alpha ranging from 0.797 to 0.855.

Confidence
Two of the Scales from the PBCCS were used to measure confidence. The first is 'Bereavement Support Knowledge Scale' which contains 3 subscales; 'General knowledge of bereavement support needs', 'Knowledge of the emotional needs of bereaved parents', 'Continuous perinatal bereavement support knowledge development of maternity care professionals'.
The second subscale is 'Bereavement Support Skills Scale' which contains 2 sub-scales; 'Bereavement support specific interpersonal skills' and 'Bereavement support functional skills'.

Self-awareness
Participants self-awareness was measured using the PBCCS Self-awareness Scale (Kalu *et al*., 2016). The PBCCS Self-awareness scale contains 2 subscales measuring the 'Awareness of the needs of bereaved parents' and 'Awareness of my personal needs in relation to providing bereavement support'.

Organisational support
Organisational Support was measured using the PBCCS Organisational Support Scale (Kalu *et al.*, unpublished Thesis UCD, 2016). The PBCCS Organisational support scale contains 2 subscales measuring; 'Support for staff providing bereavement care' and 'Environmental and workload influences'.

Self-Compassion
Participants Self-Compassion was measured using the Self-Compassion Scale–Short Form (SCS–Sf) (Raes *et al.* 2011) *See Appendix 6*. This scale was developed from the Self Compassion Scale (SCS) 24 item scale (Neff 2003), which contains six components of self-compassion including: Self-Kindness; Self-Judgment; Common Humanity; Isolation; Mindfulness, Over-identification. The SCS–Sf scales are scored using a 5 point likert scale ranging (1-5). The total self-compassion score was obtained by reverse scoring the negative subscale items - self-judgment, isolation and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) followed by computing a total mean. Good psychometric properties have been reported by Raes *et al.* (2011) with a Cronbach's alpha value of 0.86.

Socio-demographic information [measured at time 1 only]
Information on age range, gender, level of education and prior work experience was captured.

3.9.5 Data Analysis: Quantitative Data

Quantitative data obtained from the questionnaires was analysed by computer using IBM Statistical Package for the Social Sciences (SPSS version 24.0) and $p<.05$ was set as significant. Both descriptive and inferential statistics were used in the analysis and description of the data set through the use of univariate and bivariate statistics. Descriptive statistics (frequencies, frequency percents, measures of central tendency, and measures of variability) was used to summarise results from the instruments used in the study. The types of nonparametric inferential tests used to analyse data was determined by the level of measurement and assumptions of normality. A series of repeated measures ANOVA's was used to address the main study questions.

3.10 Process Evaluation / Qualitative Data from two Focus Groups

3.10.1 Sampling

Convenience Sampling was used to recruit participants.

3.10.2 Inclusion / Exclusion Criteria

Students who had participated in the Educational Training Workshop on Bereavement Care (ETWBC) were included in the focus group.

Exclusion criteria included students who did not wish to participate and students who had recently suffered bereavement.

3.10.3 Data Collection

A Focus group (n=6) was held with consenting members from each group of students (4th year Midwifery and 1st year Higher Diploma Midwifery Students) within 10 days of completing the Educational Training Workshop on Bereavement Care in Clinical Practice. A total of 12 students participated in the focus groups. At the end of each focus group, the facilitator and co-facilitator had a debriefing session whereby any issues which needed clarification or confirmation were outlined. Their impressions of agreement and expressed or non-verbal dissent were discussed, as recommended by Kidd and Parshall (2000). The following questions were asked in the focus group:

Table 1: Focus Group Question Format

Question 1
Can you tell me please how much exposure you have had to bereaved families?
Question 2
How did you experience the overall day? Was there any specific parts of the day the you found most useful? And Why? What was the least useful? And Why?
Question 3
Using audio recordings during role play/simulation are useful ways to give feedback to students would you think audio recordings would be helpful to include in a workshop on Bereavement care?
Question 4
What more can be done to promote student midwives' bereavement supports skills in clinical practice/education programme?
Question 5
Did the knowledge you received on Bereavement, Grief and Loss in class help prepare you for practice in this area? If not what do you think might be help to include in the curriculum? If it did what do you think helped most in your experience?
Question 6
What more can be done to promote student midwives' bereavement supports skills?
Question 7
How did you feel emotionally after the workshop?

3.10.4 Data Collection Instrument

The Focus group discussion was audio recorded and data transcribed.

3.10.5 Data Analysis: Qualitative Data

Thematic Network Analysis, guided by Attride-Sterling (2001) was chosen to be the most appropriate method of data analysis of the focus group data, in the current study. Braun and Clarke (2014) advocate for qualitative data analysis which is deliberative, reflective and thorough and believe that thematic analysis is a tool that can serve these purposes well. Attride-Sterling (2001) developed a series of steps to follow for thematic analysis. These steps were followed in the analysis of this study's data. Validation of the emergent themes was achieved through discussion with 2 other members of the research team, to confirm findings.

Steps in analysis employing Thematic Analysis (Attride-Sterling, 2001, pp. 391):

Analysis Stage A: reduction or Breakdown of Text

Step 1. Code material

a) Devise a Coding Framework
b) Dissect text into text segments using the Coding Framework

Step 2. Identify Themes

a) Abstract themes from coded text segments
b) Refine themes

Step 3. Construct Thematic Networks

a) Arrange Themes
b) Select Basic Themes
c) Rearrange into Organising Themes
d) Deduce Global Theme
e) Illustrate as Thematic Network
f) Verify and Define Network

Analysis Stage B: Exploration of Text

Step 4. Describe and Explore Thematic Network

a) Describe the Network
b) Explore the Network

Step 5. Summarise Thematic Network

Analysis Stage C: Integration of Exploration

Step 6. Interpret Patterns

Chapter 4: Results from the Outcome Evaluation

This chapter presents the findings of the quantitative aspect of the study which used the 2 questionnaires to address the following research questions:

1. *What are the Knowledge and the Skills required by Student Midwives (4th Year Internship and Higher Diploma in Midwifery) to deliver bereavement care to parents following a pregnancy loss or perinatal death?*
2. *Does participation in an educational training workshop in bereavement care improve Student Midwives' knowledge and skill to deliver bereavement care to parents following a pregnancy loss or perinatal death?*
3. *Does participation in an educational training workshop in bereavement care improve Student Midwives' self-awareness to deliver bereavement care to parents following a pregnancy loss or perinatal death?*
4. *Does participation in an educational training workshop in bereavement care improve Student Midwives' self-compassion to deliver bereavement care to parents following a pregnancy loss or perinatal death?*
5. *Is Organisational Support related to Student' Midwives confidence to provide bereavement care to parents following a pregnancy loss or perinatal death?*

4.1 Demographics

Total Sample:

39 of the 41 Higher Diploma and 4th year BSc students participated in the workshop and 38 of these students filled out all 3 questionnaires. This is a response rate of 97.44%.

Gender:

All of the participating students were female.

Educational Programme:

55.3% (n=21) of the participants were Higher Diploma Midwifery students and 44.7% (n=18) of the participants were 4th year BSc Midwifery student interns.

Age:

78.9% (n=30) of the participants were 20-29 years of age.
15.8% (n=6) of the participants were 30-39 years of age.
5.3% (n=2) of the participants were 40-49 years of age.

Previous Experience in the Nursing Industry:

With regard to experience working in the nursing industry prior to commencement of their present midwifery programme, 44.7% (n=18) (all of the BSc students) had no previous experience.
18.4% (n=7) had 1-2 years' experience;
15.8% (n=6) had 3-4 years' experience;
13.2% (n=5) had 5-6 years' experience;
No participants had 7-8 years' experience;
2.6% (n=1) had 9-10 years' experience;
5.3% (n=2) had over 10 years' experience.

Outcome Evaluation: Questionnaires

The questionnaires were completed at three time intervals.
Time 1 (T1) was prior to the workshop
Time 2 (T2) was within one week of participating in the workshop
Time 3 (T3) was three months after the workshop

4.2 Knowledge and Skill Requirements:
What are the Knowledge and the Skills required by Student Midwives (4th Year Internship and Higher Diploma in Midwifery) to deliver bereavement care to parents following a pregnancy loss or perinatal death?

4.3 Outcome Evaluation - Primary Outcome:

4.3.1 Confidence
Does participation in an educational training workshop in bereavement care improve Student Midwives' (confidence) as measured by knowledge and skill to deliver bereavement care to parents following a pregnancy loss or perinatal death?

The confidence of the student midwives to provide bereavement care to parents who have experienced a perinatal loss was measured using 2 subscales from the PBCCS namely, Bereavement Support Knowledge and Bereavement Support Skills.

A one-way repeated measures ANOVA was conducted to compare Student Midwives level of the bereavement support knowledge at Time 1 (prior to the ETWBC), Time 2 (1 week following the ETWBC) and Time 3 (3-month follow-up) (see Table 2). Mauchly's Test of Sphericity was non-significant and Sphericity was assumed. There was a statistically significant difference [$F(2,72)=21.150$, $p<.000$, partial eta squared= 0.370] in Student Midwives level of bereavement support knowledge between the 3 Time Points in this study. Post hoc Bonferroni tests indicated that Student Midwives bereavement support knowledge prior to participating in the ETWBC (M=55.08, SD 3.83) was significantly lower ($p<.005$) than their level of Bereavement Support Knowledge following their participation in the ETWBC (M=57.03, SD 2.95) and was also was significantly lower ($p<.000$) than their level at 3 months follow-up (M=58.65, SD3.54). In summary, Student Midwives bereavement support knowledge improved following their participation in the educational training workshop in bereavement care, and this improvement was sustained a 3months follow-up.

Table 2 Descriptive statistic for Student Midwives Bereavement Support Knowledge

	Bereavement Support Knowledge T1	Bereavement Support Knowledge T2	Bereavement Support Knowledge T3
N	37	37	37
Mean	55.0811	57.0270	58.6486
Std. Deviation	3.83245	2.94851	3.53723

A one-way repeated measures ANOVA was conducted to compare Student Midwives level of the bereavement support skill at Time 1 (prior to the ETWBC), Time 2 (1 week following the ETWBC) and Time 3 (3-month follow-up) (see Table 3). Mauchly's Test of Sphericity was significant ($p<.008$) therefore Greenhouse-Geisser results were used. There was a statistically significant difference [$F(1.6,60)=48.460$, $p<.000$, partial eta squared = 0.567] in Student Midwives level of bereavement support skill between the 3 Time Points in this study. Post hoc Bonferroni tests indicated that Student Midwives bereavement support skills prior to participating in the ETWBC (M=27.74,

SD=4.64) were significantly lower (p<.000) than their level of bereavement support skills following their participation in the ETWBC (M=32.58, SD 3.10) and were also was significantly lower (p<.000) than their level at 3 months follow-up(M=33.84, SD=3.26). In summary, Student Midwives bereavement support skills improved following their participation in the educational training workshop in bereavement care, and this improvement was sustained at a 3month follow-up.

Table 3 Descriptive statistics for Student Midwives Bereavement Support Skills

	Bereavement Support Skills T1	Bereavement Support Skills T2	Bereavement Support Skills T3
N	38	38	38
Mean	27.7368	32.5789	33.8421
Std. Deviation	4.63643	3.08117	3.25930

4.3.2 Outcome Evaluation - Secondary Outcomes:

Self-awareness

Does participation in an educational training workshop in bereavement care improve Student Midwives' self-awareness to deliver bereavement care to parents following a pregnancy loss or perinatal death?

The self-awareness of the student midwives to provide bereavement care to parents who have experienced a perinatal loss was measured using 2 subscales ('Awareness of the needs of bereaved parents' and 'Awareness of my personal needs in relation to providing bereavement support') from the PBCCS.

A one-way repeated measures ANOVA was conducted to compare Student Midwives level of self-awareness of the needs of bereaved families at Time 1 (prior to the ETWBC), Time 2 (1 week following the ETWBC) and Time 3 (3-month follow-up) (see Table 4). Mauchly's Test of Sphericity was non-significant and Sphericity was Assumed. There was a statistically significant difference [$F(2,72)= 20.311$, p<.000, partial eta squared = 0.361] in Student Midwives level of self-awareness of the needs of bereaved families between the 3 Time Points in this study. Post hoc Bonferroni tests indicated that Student Midwives self-awareness prior to participating in the ETWBC (M=18.86, SD 2.8) was significantly lower (p<.000) than their level of level of self-awareness needs of bereaved families following their participation in the ETWBC (M=20.92, SD 2.31) and was also was significantly lower (p<.000) than their level at 3 months follow-up (M=21.59, SD1.8). In summary, Student Midwives self-awareness of the needs of bereaved families improved following their participation in the educational training workshop in bereavement care, and this improvement was maintained at a 3month follow-up.

Table 4 Descriptive statistics for Student Midwives self-awareness needs of bereaved families.			
	Self-Awareness needs of bereaved families T1	Self-Awareness needs of bereaved families T2	Self- Awareness needs of bereaved families T3
N	37	37	37
Mean	18.8649	20.9189	21.5946
Std. Deviation	2.78051	2.31395	1.78667

A one-way repeated measures ANOVA was conducted to compare Student Midwives level of the self-awareness of personal needs in relation to providing bereavement support at Time 1 (prior to the ETWBC), Time 2 (1 week following the ETWBC) and Time 3 (3-month follow-up) (see Table 5). Mauchly's Test of Sphericity was significant (p<.028) therefore Greenhouse-Geisser results were used. There was a statistically significant difference [*F*(1.7, 61)=30.387, p<.000, partial eta squared = 0.458] in Student Midwives level of self-awareness of their personal needs in relation to providing bereavement support between the 3 Time Points in this study. Post hoc Bonferroni tests indicated that Student Midwives self-awareness of their personal needs in relation to providing bereavement support prior to participating in the ETWBC (M=9.89, SD 1.74) was significantly lower (p<.000) than their level of self-awareness of their personal needs following their participation in the ETWBC (M=12.00, SD 1.53) and was also was significantly lower (p<.000) than their level at 3 months follow-up (M=12.16, SD 1.90). In summary, Student Midwives self-awareness of their personal needs in relation to providing bereavement support improved following their participation in the educational training workshop in bereavement care, and this improvement was sustained at a 3month follow-up.

Table 5 Descriptive statistic for Student Midwives Self-awareness of personal needs in relation to providing bereavement support			
	Self-Awareness personal needs T1	Self-Awareness personal needs T2	Self- Awareness personal needs T3
N	37	37	37
Mean	9.8919	12.0000	12.1622
Std. Deviation	1.74458	1.52753	1.89317

Self-Compassion

Does participation in an educational training workshop in bereavement care improve Student Midwives' self-compassion to deliver bereavement care to parents following a pregnancy loss or perinatal death?

A one-way repeated measures ANOVA was conducted to compare Student Midwives level of the Self-compassion at Time 1 (prior to the ETWBC), Time 2 (1 week following the ETWBC) and Time 3 (3-month follow-up) (see Table 6). Mauchly's Test of Sphericity was non-significant and Sphericity was assumed. There was no statistically significant difference [*F*(2,60)=0.104, p<.901, partial eta

squared = 0. 003] in Student Midwives level of self-compassion between the 3 Time Points in this study. In summary, Student Midwives self-compassion did not change following their participation in the educational training workshop in bereavement care and at 3months follow-up.

Table 6 Descriptive statistics for Student Midwives Self-compassion

	Self-compassion T1	Self-compassion T2	Self-compassion T3
N	37	37	38
Mean	38.5806	38.7419	38.8710
Std. Deviation	5.05816	4.48478	5.04475

Organisational Support

Is Organisational Support related to Student' Midwives confidence to provide bereavement care to parents following a pregnancy loss or perinatal death?

A Pearson moment correlation analysis was completed at each time point (Time 1 prior to the ETWBC), (Time 2,1 week following the ETWBC) and (Time 3, 3-month follow-up) to examine the relationships between Student Midwives confidence (namely Bereavement Support Knowledge and Bereavement Support Skills) and Organisation Support (namely Support for Staff Providing Bereavement Care and Environmental and Workload influences). The correlation matrixes are presented in Table 7; Table 8; Table 9.

At Time 1 (prior to the ETWBC), there was a strong positive relationship between Bereavement Support Knowledge N38, r=.453,p<.00 (2 tailed) and Bereavement Support SkillsN38, r=.585,p<.00 (2 tailed) and Organisation Staff Support for Providing Bereavement Care. There were no relationships detected between; Bereavement Support Knowledge and Organisation Support Environment and Workload, Bereavement Support Skill and Organisation Support Environment and Workload.

Table 7 Pearson moment correlations Time 1 Bereavement Support Knowledge and Bereavement Support Skills and Organisational Support Scales

		Time 1 Bereavement Support Knowledge Total	Time 1 Bereavement support Skill Total	Time 1 Organisation staff support for providing Bereavement Care	Time 1 Organisation support environment and workload
Time 1 Bereavement Support Knowledge Total	Pearson Correlation	1	.583**	**.453****	.249
	Sig. (2-tailed)		.000	.004	.132
	N	38	38	38	38
Time 1 Bereavement Support Skill Total	Pearson Correlation	.583**	1	**.585****	.271
	Sig. (2-tailed)	.000		.000	.100
	N	38	38	38	38
Time 1 Organisation Staff Support For Providing Bereavement Care	Pearson Correlation	.453**	.585**	1	.294
	Sig. (2-tailed)	.004	.000		.074
	N	38	38	38	38
Time 1 Organisation Support Environment And Workload	Pearson Correlation	.249	.271	.294	1
	Sig. (2-tailed)	.132	.100	.074	
	N	38	38	38	38

**. Correlation is significant at the 0.01 level (2-tailed).

At Time 2 (1 week following the ETWBC) there was a strong positive relationship between Bereavement Support Knowledge N37, r=.537 p<.00 (2 tailed) and Organisation Staff Support for Providing Bereavement Care and Bereavement Support Skill N37, r=.580,p<.00 (2 tailed) Organisation Staff Support for Providing Bereavement Care. There were no relationships detected between; Bereavement Support Knowledge and Organisation Support Environment and Workload, and Bereavement Support Skill and Organisation Support Environment and Workload subscales.

Table 8 Pearson moment correlations Time 2 Bereavement Support Knowledge and Bereavement Support Skills and Organisational Support Scales

		Time 2 Bereavement Support Knowledge Total	Time 2 Bereavement support Skill Total	Time 2 Organisation staff support for providing bereavement	Time 2 Organisation support environment and workload
Time 2 Bereavement Support Knowledge Total	Pearson Correlation	1	.652**	**.537****	.102
	Sig. (2-tailed)		.000	.001	.542
	N	38	38	37	38
Time 2 Bereavement Support Skill Total	Pearson Correlation	.652**	1	**.580****	.083
	Sig. (2-tailed)	.000		.000	.620
	N	38	38	37	38
Time 2 Organisation Staff Support For Providing Bereavement	Pearson Correlation	.537**	.580**	1	.113
	Sig. (2-tailed)	.001	.000		.507
	N	37	37	37	37
Time 2 Organisation support environment and workload	Pearson Correlation	.102	.083	.113	1
	Sig. (2-tailed)	.542	.620	.507	
	N	38	38	37	38

**. Correlation is significant at the 0.01 level (2-tailed).

At Time 3 (3-month follow-up) there was a strong positive relationship between Bereavement Support Knowledge N37, r=.433 p<.01 (2 tailed) and Organisation Staff Support for Providing Bereavement Care and Bereavement Support Skill N37, r=.488,p<.00 (2 tailed) Organisation Staff Support for Providing Bereavement Care. There were no relationships detected between; Bereavement Support Knowledge and Organisation Support Environment and Workload, and Bereavement Support Skill and Organisation Support Environment and Workload subscales.

Table 9 Pearson moment correlation results for Time 3 Bereavement Support Knowledge and Bereavement Support Skills and Organisational Support Staff

		Time 3 Bereavement Support Knowledge Total	Time 3 Bereavement support Skill Total	Time 3 Organisation staff support for providing bereavement	Time 3 Organisation support environment and workload
Time 3 Bereavement Support Knowledge Total	Pearson Correlation	1	.475**	**.433****	.105
	Sig. (2-tailed)		.003	.007	.541
	N	37	37	37	36
Time 3 Bereavement Support Skill Total	Pearson Correlation	.475**	1	**.488****	.225
	Sig. (2-tailed)	.003		.002	.180
	N	37	38	38	37
Time 3 Organisation Staff Support For Providing Bereavement	Pearson Correlation	.433**	.488**	1	.153
	Sig. (2-tailed)	.007	.002		.366
	N	37	38	38	37
Time 3 Organisation Support Environment And Workload	Pearson Correlation	.105	.225	.153	1
	Sig. (2-tailed)	.541	.180	.366	
	N	36	37	37	37

**. Correlation is significant at the 0.01 level (2-tailed).

4.3.3 Summary

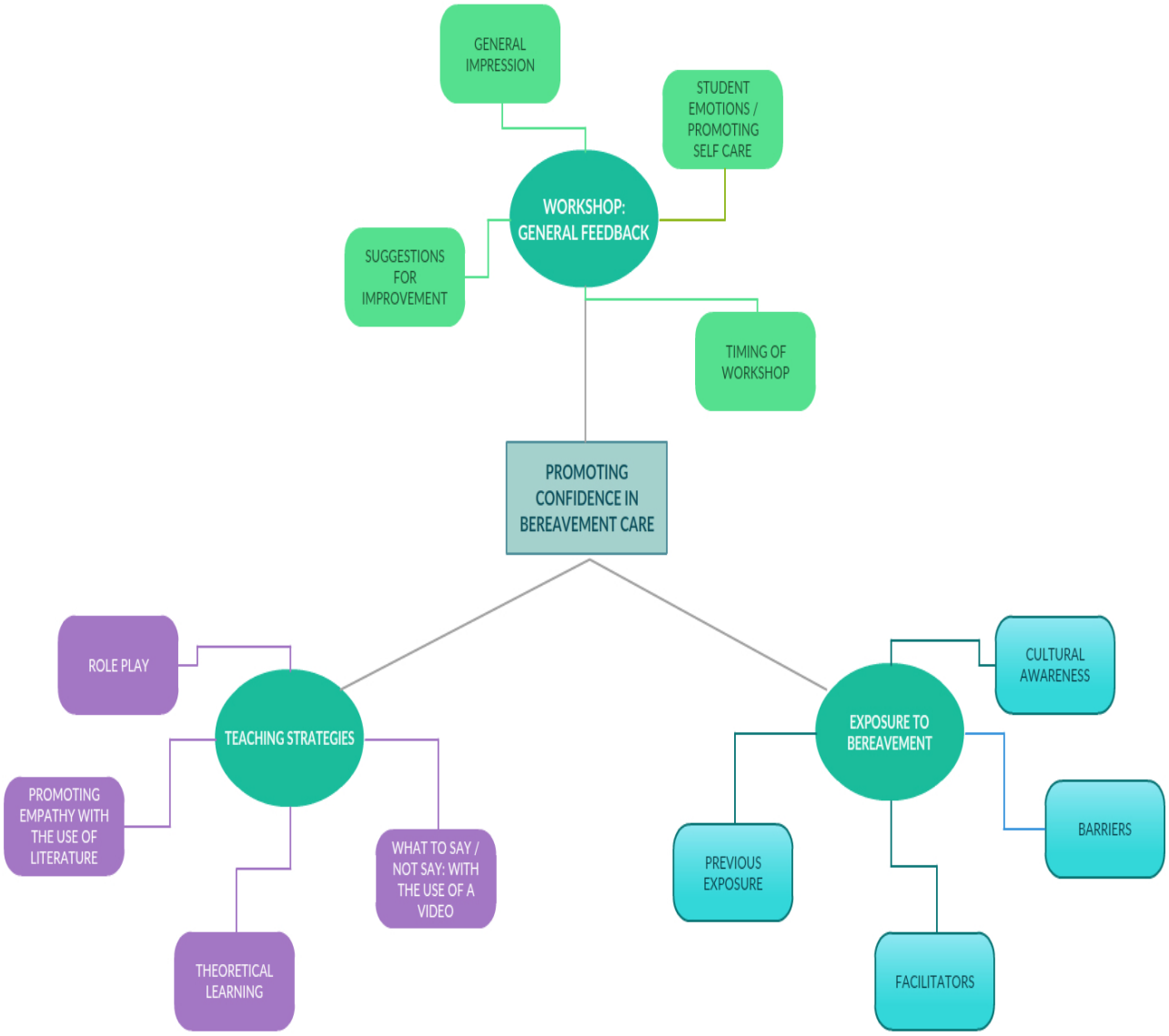
Student Midwives confidence (bereavement support knowledge, bereavement support skill) and their self-awareness of the needs of bereaved families and of their personal needs in relation to providing bereavement support improved following their participation in the educational training workshop in bereavement care, and this improvement was maintained at 3month follow-up. Student Midwives self-compassion did not change following their participation in the educational training workshop in bereavement care and at 3months follow-up. Finally, at all three time points(Time 1prior to the ETWBC), (Time 2,1 week following the ETWBC) and (Time 3, 3-month follow-up) strong positive relationships were detected between Student Midwives' Bereavement Support Knowledge and Bereavement Support Skills and the Organisational Support for Staff Providing Bereavement Care. However no significant relationships were detected between Student Midwives' Bereavement Support Knowledge and Bereavement Support Skill and Organisation Support Environment and Workload in the study.

Chapter 5: Results from the Process Evaluation

This chapter presents the findings of the qualitative aspect of the study, which involved the use of focus groups to gain greater depth of information in relation to the students' experience of participating in the workshop and what are the facilitators and barriers to gaining confidence to provide quality bereavement care. This qualitative information helped to explain, enhance and build upon the findings from the questionnaires.

5.1 Results of Thematic Network Analysis of Two Focus Groups:

Figure 2: Thematic Network



Two focus groups were conducted, by the facilitator and a co-facilitator. The lead facilitator was the Research Assistant for the study, a midwife in clinical practice. The co-facilitator was the gate-keeper for the study, a midwife and academic. In order to remain un-bias, thus maintaining the validity of the study, neither the facilitator nor co-facilitator had any involvement in the development of the workshop. The facilitator was present at both workshops, to provide organisational support, but had no involvement in the development of the workshop. The co-facilitator was not present at either workshop.

Both focus groups were held within 10 days of the perspective workshops. Each focus group had 6 student participants. A template of questions was compiled for the semi-structured focus groups, in advance, and agreed by the research team. The same questions were asked to both focus groups, and prompts were used, when necessary. For the purpose of the thematic analysis, the data received from both focus groups was amalgamated, unless specific questions yielded different answers or discussions between both groups. In this case, these differences will be discussed.

The audio recordings were transcribed within two days of both focus groups, by the facilitator/research assistant. This transcript was then checked and re-checked against the original recordings, to ensure fidelity to the discussion, and any small amendments were made, followed by manual coding of the data. After that, the process of thematic analysis commenced, where emergent themes were identified, compared and refined to form final categories.

Three organising themes were identified, using Attride-Sterling's method for Thematic Network Analysis:

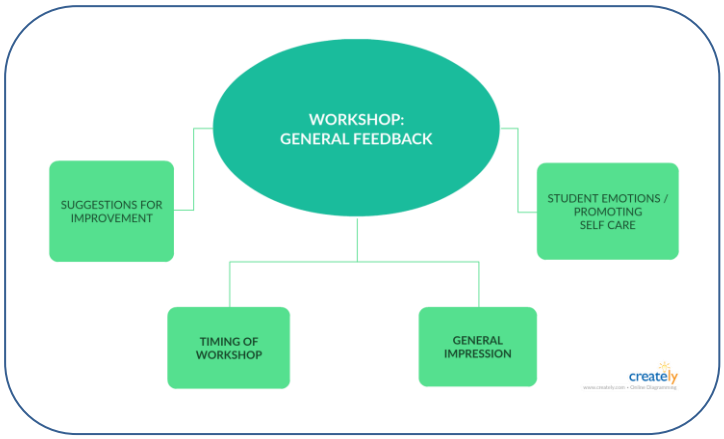
1) **The Workshop**
2) **Teaching Strategies**
3) **Exposure to Bereavement**

Each of these has 4 basic themes. These will be discussed below.
From these organising themes, one global theme was identified:

Promoting Confidence in Bereavement Care.

Organising Theme 1: Workshop:

The four basic themes for the organising theme entitled 'Workshop' are: General Impression; Student Emotions/Promoting Self-Care; Timing of Workshop; Suggestions for Improvement.



Basic Theme 1.1: General Impression:

The general feedback from the workshop was extremely positive, with all of the students agreeing that their confidence did increase, in the provision of bereavement care, after the workshop.

> *"...it just kind of cemented things alot more and we need more days like that..."*

> *"I liked it. Especially the role plays. I thought it gave all, just all the practical stuff...The cot and everything. That's what I liked I think the most."*

> *"Yeh I thought it was very beneficial. Really nice. It just explained all the services we offer again. For, like, the photography and everything, and just be a bit more familiar with it."*

> *"It made me realise that although I had doubts about what I said or the conversation, actually no, actually I didn't do that bad...It kind of gave me a bit more confidence. I wasn't worried, you know when you're thinking back."*

Although the students found the workshop beneficial, they were also very realistic about their expectations of it. It was mentioned that they will never be too prepared for caring with someone suffering with bereavement.

> *"I think we're never gonna be fully prepared. It's gonna be traumatic, it's gonna be awful."*

> *"We all remember the first times of alot of things in general nursing and unfortunately it's probably gonna be the same here."*

> *"I don't think you'll ever be too prepared for it."*

The layout and atmosphere of the room was commented on as having a very positive and calming effect on the students. The fact that they were given sweets at different intervals during the day, tea

at the end of the day, and chocolates in the butterfly mesh bags going home, was also commented on, with genuine gratitude.

> *"Bereavement is a sad and quite a heavy topic and I think it made a positive difference, the whole lay out of the place."*

> *"And I think it was just such a soft, calm day that I feel if I am confronted with it here, that hopefully, I'll remain, that kind of calmness will stay with me."*

> *"...Coming in, the room was set up really really nicely and we were all comfortable for the day and we had those few minutes to reflect as well, at the end."*

> *"I know this sounds really weird, you gave us bags of sweets at the end, and told us to mind ourselves, which I thought was really nice."*

Basic Theme 1.2: Student Emotions / Promoting Self care

There were mixed emotions at the end of the day. The Higher Diploma students who had experience with dealing with bereavement, prior to the workshop, were more emotionally effected by the content of the workshop, and the memories that were brought back, as a result.

> *"Just brought back, I suppose, lots of memories. Made you think of people you've looked after."*

> *"But I felt it brought back alot of, the whole day brought back alot of, like, memories of bereavements that I would have had myself, and I just found it really helpful at the end of the day, 'coz I was, you know, it was sad."*

The BSc students, however, who had little or no previous experience working in a palliative care or perinatal bereavement capacity, stated that, although it was a heavy and sad topic, and they were tired after the day, they were not too emotionally affected.

> *"I haven't actually experienced any bereavement myself, so I wasn't, emotionally, like, I found it sad, but it didn't affect me much, you, I just felt okay after."*

Even though some found themselves tired and emotional afterwards, there was an agreement that the workshop was still beneficial, despite the emotions felt.

> *"You know, it's sad, but it's reflective and it was helpful and I was glad that we went."*

> *"I know it's not a nice side to midwifery, and I get that part, but it's part of it."*

The mindfulness section at the end of the day, which was incorporated, to promote self care was positively received by most of the students and allowed them to think about the importance of their own self care, going forward.

"I like that we had time to look after ourselves... I think it's really important and I don't think it was really stressed before. Like, in midwifery, really stressed...when it really should have been."

"Like we can't see stuff like that and, like, not be affected. You know, it's going to build up, moving on in our careers. Everything is going to build up. So, yeh I think it emphasised that."

"I found it very helpful because it was just too heavy a topic for me without having some kind of wind down thing afterwards."

Some of the students were less impressed by the mindfulness, with a few mentioning that they fell straight asleep during the meditation.

"I like it, and I have an interest in it, but as a person, I just don't slow down, 'til I fall down."

"Not the meditation, I wouldn't be into that, but I have my own little ways."

"The only other thing about the day was how it was lovely to do the relaxation at the end of the day, but I don't know how beneficial it was, say, tying in with the whole thing in the day itself. I possibly would have rather more time doing role play or some sort of other scenario where we just improved our skill and our language set."

"It's a nice idea but I did just fall asleep."

Even though not all of the students reacted positively to the different aspects of the mindfulness, they did agree that it re-iterated the promotion of self-care, which was the core motivation behind the decision to incorporate it. Also, there was ample appreciation for the effort made, by the facilitators, to make the students feel looked after and genuinely cared for.

"It just kind of re-enforced the idea of looking after yourself, rather than go get a meditation tape or anything."

"I felt it was a good bonding experience. Everyone was all huggy at the end, having chocolate and tea, saying 'are you minding yourself'? I just thought it was really nice to end it that way, together as a class."

"You know, like we were all sitting there with blankets on us, and you brought us tea and chocolate, and you know, we kind of, yeh , you, kind of rely on your partner or your family to mind you when you go home from work and It's good to know that, you know, work wants you to be minded aswell."

"I think that it made me think more about the fact that it is so important to look after ourselves, you know.

"'Coz I know it's just bags of sweets, but it made me feel like 'Oh yeh, they really mean it'."

Basic Theme 1.3: Timing of the Workshop

There were discussions about the timing of the workshop, by both groups, with a wide variety of suggestions made. The BSc students had their workshop in the third month of their internship year, during one of their monthly reflection days. Most of these students suggested, going forward, that the workshop would be beneficial earlier in their training, while some were happy with the timing, as they had knowledge and clinical experience coming into the workshop. The students discussed the reasons for faculty not bringing this type of workshop forward, into, say their first year, as they know the curriculum concentrates on normal childbirth only, in the first year of the four year programme. However, they appreciated that loss is an unfortunate part of birth for many, and, as such, is not an abnormal topic. Most of the participants, therefore, agreed that it is important to commence preparation for bereavement care earlier in their training.

> *"But definitely going into second year placement, I would have liked to do maybe a day or something..."*
>
> *"I think awareness needs to be made (earlier in the program) 'coz I was exposed in first year. I was only small."*
>
> *"It does happen and it is normal. I don't think IUD is such an abnormal topic."*
>
> *"You remember things a bit better if they're later, in a way."*

The Post Reg students' workshop was during exam week of their second semester. They had undertaken an exam the previous day and were due to do another one the following day. As a result, even though they remained engaged during the workshop, they were quite tired, and this was mentioned during the focus group.

> *"I think somewhere away from block, somewhere... No-one is worried about assignments or study or deadlines like that... Or even at the start of block, where the workload hasn't been thrown too deep."*
>
> *"But to be like 2 months into it, like maybe just after Christmas or something... maybe I might have put myself, tried to put myself forward a little bit more if I felt more confident, you know, so maybe, just a few months ago, you know."*
>
> *"Perhaps maybe, within those first few weeks, it would have been better to do this workshop. And then when we also feel, going forward... NMH does care about us aswell, and it just might make us feel a bit calmer."*

Basic Theme 1.4: Suggestions for Improvement

The facilitator asked the participants how their 'confidence' can be further improved, and then asked how there 'competence' can be further improved. When answering these questions, both groups did not differentiate between the two – confidence and competence, and answered, using similar phrases and / or recommendations for both questions. For this reason, we have amalgamated these answers into one theme.

The majority of the suggestions were actually requests for additional content to be included in future / follow on workshops, rather than changes or omissions to the one they participated in. Quite a number of suggestions were made for an expansion to the role plays and different recommendations were made for different scenarios to be played out. Most students commented on the length of time allocated for the role-plays, an although they appreciated the other aspects of the day, and understood that allocating more time during that particular day was unrealistic, they were all in agreement that these role plays were hugely beneficial and they would appreciate more bereavement care study days, involving role plays, which would increase their confidence in different scenarios. Incorporating role plays which include partners, and discussing how to break bad news to siblings, came up on several occasions.

> *"...just another topic to touch on would be telling siblings, talking to the siblings about it..."*

> *"Can I also suggest another thing? To have a partner there. Like a hypothetical partner there for the scenarios."*

> *"...have a practical lab where we just do role plays of bereaved parents."*

Other suggestions were made regarding the expansion of the role plays. Some students suggested the bereavement midwives giving an example of an 'ideal' scenario. Others suggested watching a video of a 'good' and a 'bad' scenario, so that they can be discussed as a group.

> *"Or perhaps look at the professionals doing their own scenarios, so that you can take things from it, or, as opposed to critiquing ourselves, who aren't skilled in that particular area."*

> *"But I don't know what else could be said and what bits would have been left out that may have been of importance as well... I'd like to see a bereavement trained midwife do the scenario... because she's doing it to the highest standard."*

> *"Or even just watch the 2 midwives. Because everything they said was, I don't know, I just thought it was really nice."*

> *"I'd like for a scenario to be played out and for people to say 'oh, I think that was good', and 'oh, maybe you shouldn't have said that', and for there to be good and bad examples in the scenario and for people to say like pick out the good things and pick out the bad things aswell, without being told, like, that they're good or bad."*

Some participants suggested more hands-on, practical, information about tests that need to be run and how to dress and bath the baby.

> *"Do you know, I don't really know, I presume you bath them, the babies, or whatever? We didn't actually really go into that."*

> *"When it comes to forms that you have to fill out, bloods, and, I know that there are those flow chart things of what to do. Like, I don't know, I know there's one, but I don't know what it is, It's not in my head, like maybe if someone was on the ward with us, 'coz I feel working with preceptors, I'd never experienced that, so there's alot of us that haven't."*

Another comment was made about the lack of confidence they still have in providing care to a woman during, and immediately after, the diagnosis of a miscarriage or IUD.

> *"I think it's prepared me for, say, 6 hours after she's delivered and like that period. I don't think it prepared me for a woman who comes into unit 3 and there's no heartbeat and she's there, and she's saying we're gonna keep her in or go home and come back in the next day. I am in no way prepared for that situation."*

Also, some participants brought up a request for more photographs to prepare them.

> *"I think more images to prepare ourselves or more days with the girls."*

> *"I think as (H4) said, I think more images to prepare ourselves or more days with the girls."*

> *"So that was my first, I just had to walk in and go 'oh, he's beautiful', and I was shocked. And I'm trying to pretend I'm not shocked."*

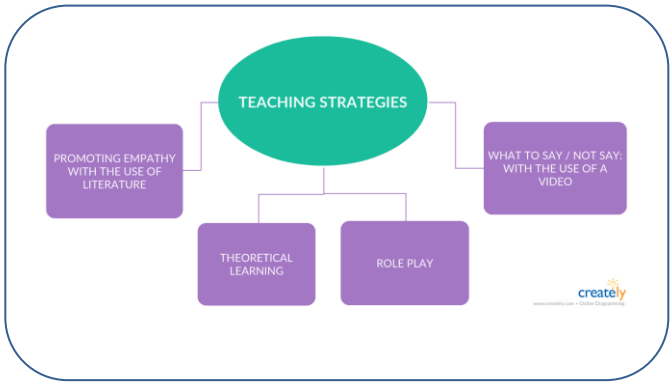
Also requested was more information on cultural / religious care. This discussion was deemed large enough to create its own basic theme, and as such, is discussed below.

<u>Organising Theme 2: Teaching Strategies:</u>

The 'Teaching Strategies' organising theme includes 4 basic themes. The first 3 themes were predominantly broken down by the different elements of the workshop: The Role Play; What to Say / Not Say; The Use of Literature to Improve Empathy. The fourth theme included information about theoretical learning in college.

Using different teaching strategies kept the students engaged and they enjoyed the variation during the day. As mentioned above, the use of literature, audio visual and role play were used, as well as bringing in samples of items, such as a cool cot, leaflets, filled memory boxes, clothing and sibling books and teddy's. Students commented on the variety in a positive manner.

> *"I thought it was good the fact that you had, like, the powerpoint slide and then the role play and then the poem and then the mindfulness, like the mixture of different things."*



Basic Theme 2.1: Role Play:

The role plays were deemed the best part of the day by all students, and when asked about the general impression of the day, some students immediately started discussing the role plays, as the main aspect of the day.

> *"And the role plays were definitely really helpful and that. I definitely think the role plays were the best part of the day."*

> *"You could see how it would happen in real life. There was nothing uncomfortable about it... Everything they said, you were just going, 'oh yeh, like, that's what you'd see'."*

The majority of the students discussed the need for more time doing role plays, to give more students the opportunity to be the participant in the role-play, as the midwife looking after the woman.

> *"I felt the role play was very good, but then I wasn't an onlooker, I was a participant."*

> *"I found the participant thing was actually good. I probably would be easily distracted watching."*

> *"So it's a little bit like anything, until you actually practice it yourself it's very easy to, kind of, observe and say 'oh yes I do have to actually practice the skill yourself."*

Although most either appreciated being able to participate, or would have liked to participate, it was requested by one participant that students not be forced to participate, as it would have caused discomfort for some students.

> *"I don't know if I would've liked to have done it in front of people, so I think, like, I don't think it would be right to say you have to do this."*

Basic Theme 2.2: What to Say / Not Say:

This moving video received mixed reactions, with most students finding it beneficial and informative, giving relevant and helpful advice, and some finding it upsetting.

> *"I thought it so helpful, what she was saying to do and not to do."*

> *"Obviously, I'm a mom, so maybe that just upset me more, but I'd be aware of what she felt, you know what I mean. But that's just."*

> *"'Coz I'd be looking at it from a practical side. I found it great. Now I know not to do that, whereas you'd be the opposite."*

> *"Upsetting, but helpful at the same time it was good exposure."*

Basic Theme 2.3: The Use of Literature to Improve Empathy:

The poem 'Elegy of a Stillborn Child' also received mainly positive reviews, with most of the students enjoying the discussion it brought. It did take some moments for some students to get into the mindset of the poem interpretation.

> *"It was good, I suppose, to get, to think in that frame of mind, like what words mean. What we say. Again, make you think about what you're saying and how that feels. What it means to the parents. It was very good."*

> *"I liked it. And this was his friend, kind of, reflecting and what his friend is going through, and you know, there's a whole circle of people affected really. It was just nice, kind of, just to think outside the box a little bit."*

> *"In the beginning of the poem I felt like I was, like, in English class. I thought, what it the point of this, like...And then when we were actually going through it, and all the lines were actually sticking out, I was like 'Oh, Wow'. That is really strong."*

> *"Like I enjoyed it afterwards, but then when we were doing it, it was like, it reminded me of school. But, it was a really nice poem."*

Basic Theme 2.4: Theoretical Learning

When asked about the value of the lectures they had received in college, about grief and loss, and bereavement care, some found the lectures beneficial, while a number of the students commented that the workshop had been more beneficial than the lectures in college. Some participants couldn't remember the lectures in college, and took a while to answer this question. Some participants requested more practical lectures, such as lectures on post mortems and other tests to be conducted after a bereavement. A few participants mentioned that photo's of babies, who had passed, would be beneficial in preparing them for the time that they will be looking after the babies and their parents'.

> *"...in college, there's alot of talk about like emotional, you know, not what to say, what not to say, but nobody says all practical stuff like what you need."*

> *"I always found the lectures helpful."*

> *"I remember the day in college but I don't remember it standing out as well as this."*

> *"I thought they did (help)...I do know how to treat women, we just don't learn how to interact with them more so."*

Organising Theme 3: Exposure to Bereavement Care

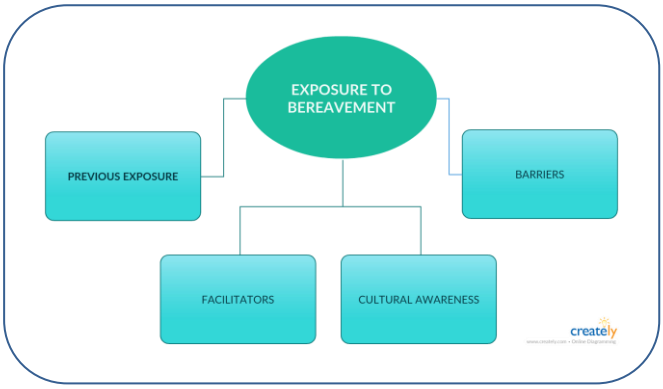
The third and final organising theme covers the students' exposure to bereavement. This also has 4 basic themes: Previous exposure; Barriers to exposure; Facilitators to exposure and Cultural awareness. The students all made similar comments concerning the importance of exposure as

early as possible, and although the workshop was deemed hugely beneficial, it was recognised that exposure was imperative to improve the confidence of all students and staff midwives.

> *"...You know if you're exposed to it, you're not really gonna have fear of it, you're going to be more supported in not worrying about it."*

> *"So she was, kind of saying she's only just qualified and she finds it daunting that this is the first experience she was being thrown in for and if she could've gone back she said 'no, get into unit 3, for all of them, if you can'."*

> *"I'm just the same, the exposure that's the biggest thing (to build competence)"*



Basic Theme 3.1: Previous Exposure

The exposure that the BSc students had received varied, but were mostly small amounts of exposure and they explained that this usually happened 'by accident', and often involved small aspects of care, such as bringing water or doing observations, rather than being involved in all aspects of the care of a bereaved mother.

> *"I think I went in once or twice to do a set of obs, but aside from that I haven't been."*

> *"It's more by pure accident if you end up in a room... If there would be an IUD, none of us would be told, be given a chance to go in."*

> *"Kinda like 'oh, can you take her obs', and that's it. You're coming in detached from the whole story."*

The students also commented on occasions where they were brought in to view the body of a baby, but didn't get to look after the mother.

> *"And then in third year, again, like accidentally. I seen a baby in the equipment room, and I was like 'ooh'."*

> *"I haven't actually been with a mother, only seen the baby."*

All of the Higher Diploma students had previous exposure, as a general nurse, in palliative care, but had very little exposure to perinatal bereavement care, in their current role as student midwife.

"I haven't had any exposure to bereavement here, yet...".

"Alot of palliative care, geriatric care and as a general nurse aswell, again, older persons. Never, never a child."

"Here, not really."

"I have some experience with bereavement and children and families and stuff, so, but not that much... Nothing here, no."

Basic Theme: 3.2: Barriers to Exposure

The largest barrier to bereavement care is the support, or lack there-of, from preceptors and senior staff, to encourage, or allow, exposure. The BSc students discussed, throughout the focus group, that they were being 'over-protected'. This over-protection was perceived as a strong barrier to exposure.

"I think there's alot of that, where they're like 'ah, you can do that at another stage, you know, you don't need to do that right now'."

"I had 2 days where there was an IUD and both days I was told there was no need for me to go in. Leave that until I'm qualified."

"...So I don't know when they expect us to, how they expect us then to just walk in and be able to deal with it."

" I feel we're very over protected from it."

"'There's no point getting bogged down. Get all your basic or normal stuff down' and they just felt there was no need."

The students commented on the fact that the confidence level and experience of the staff midwife / preceptor looking after the bereaved family can also act as a barrier or a facilitator, with one participant reflecting on an experience she had with her preceptor.

"I think it will be hard on the staff like that aswell, 'coz I remember...being with a midwife that only qualified that year...and that was the first time she ever looked after someone... And I saw her, she was so stressed and I seen her crying in the office with the managers, and I thought 'Oh, God, if she can't handle it, how am I meant to go in there'."

The Higher Diploma students also brought up discouragement from staff as a barrier to exposure, but enlightened the conversation with a different perspective to the BSc students regarding who was being overprotected. All Post reg students discussed and agreed that it was the mothers who are being protected, not the student, and perceived this to be a kind and empathic act, to improve the experience for the mother and her family at this vulnerable time.

"I think it's the mother that they're really protecting, because I think they're not really thinking about protecting us, because I think that if they're thinking of our, kind of, learning, and all that, they actually wouldn't protect us from that."

"But yeh, I do agree that, you know, you don't really want the student, you don't want her to go in and, if she doesn't have experience, you know, to upset this woman unnecessarily."

"I think they're protecting the Mom... are you going to send that person in to say something random or may do something inappropriate, then you have a worse scenario on your hands."

However, the students debated the predicament of gaining exposure at the same time as protecting the mother. Some students made suggestions, whereas some students pondered but couldn't think of a way to find the balance.

"Like, I'm not gonna do anything I'm not comfortable with, and someone senior is gonna have to come in with me if I'm not comfortable."

"I don't know how you overcome it, 'coz I do think we need exposure."

Basic Theme 3.3: Facilitators to Exposure

The most common suggestion, as a facilitator to exposure to bereavement, was to spend time with the bereavement midwives in the hospital. In recent years, the university have allocated one day with the bereavement team, in the second year of training for BSc students and two days for the Post Reg students in their first year of training. This group of BSc students, however, did not receive this time with the bereavement midwives, as the allocation to exposure to this service only commenced after their second year of training was complete. This seemed to have a negative impact on their confidence and they unanimously expressed their disappointment at not having received this exposure, and the participants expressed their interest in doing this in the future.

"I'd definitely like some time with the bereavement team. "

The time that the Post reg students did spend with the bereavement midwives was commented on in a positive manner, and some even expressed their interest in spending more than two days shadowing them.

"We need more hours on bereavement...I think, in general, you know, over the 18 months, I think more than just 2 days with the bereavement girls and a workshop. I think we need more hours than that."

"I think it was good aswell, that I had my week with the bereavement team, well the 2 days with 2...midwife specialists. It was, I picked up some bits from them which was helpful."

A few other suggestions were made to facilitate exposure. A positive relationship between the student and the preceptor was mentioned as a facilitator, as was support from staff, in general, to be given the opportunity and assistance to look after a bereaved mother. The timing and appropriateness of a students' involvement was touched on, with some students declaring their understanding of the importance of placing the mothers experience at the top of the priority list.

"To be encouraged to actually take someone who has an IUD, or has a bereavement."

"There was enough people in the room, and it's just kind of, it is a learning opportunity, but then at the same time, it should be kind of a sacred, kind of, time, that shouldn't really be interrupted by too many people..."

"I feel like, if you have a preceptor, if you work with the same preceptors most days, that if you get to know the know the student, you know, like if you get towards the end of the placement, or whatever, to maybe start to introduce the student to it."

"I actually appreciated being asked to go in to do it, rather than being sheltered from it, so."

Basic Theme 3.4: Cultural Awareness

The majority of students felt that there is a lack of cultural awareness and a lack of religious sensitivity within the hospital. One of the students recalled that she was aware of a publication, developed by the HSE, for healthcare workers, but explained that she would not know where to access it on the wards, and wouldn't have the time to look up what was looking for, due to the size of the document. All students agreed that more education around death rituals for different cultures was missing in this workshop and that they would value this education.

"I just don't think we're prepared for different religions, really, at all. But we can't prepare for every religion, but I mean, we could cover the big ones, you know."

"I think definitely going through different religions and cultures... And I just think if we had some idea and be like 'oh right'. Just have it in your head, 'right, I don't wash the baby', so make sure I go in and, you know, whatever it is... I think, like a little booklet, or something..."

3.12.1 Summary:

All of the students agreed that the workshop was of benefit, in increasing their confidence to provide bereavement care. All teaching strategies received mainly positive reviews, with the role plays being reported as the most beneficial aspect of the day. Mindfulness is very individual and although most enjoyed this aspect of the day more than others, the message, to promote self-care, was received and the students identified with the importance of this. Going forward, if this workshop was to be expanded, or a follow-on workshop were to be developed, the students suggested more complicated role plays, cultural/religious education and more images, as well as more information on tests that need to be run. The students' emotions, after the workshop, were mixed, but even the students who were upset by the subject matter of the day they were glad that they attended. All of the students appreciated the atmosphere and layout of the room and felt taken care of throughout the day.

Chapter 6: Discussion

6.1 Discussion

The primary aim of the study was to evaluate the impact of participating in the Educational Training Workshop in Bereavement Care (ETWBC) on student midwives' confidence (defined as bereavement support knowledge and bereavement support skills) to provide bereavement care to parents following a pregnancy loss or perinatal death. The secondary aim of the study was to assess the level of student midwives self-awareness, self-compassion and their experiences of organisational support, post-workshop. This evaluation study used a longitudinal sequential mixed methods design. To complete the outcome and process evaluation for the study both quantitative and qualitative methods were used. The primary aim of the study was to assess if student midwives' level of confidence to provide bereavement support care to bereaved parents improved following their participation in the bespoke ETWBC workshop. The student midwives were assessed on their level of confidence, self-awareness, self-compassion and perceptions of organisation support prior to completing the one day ETWBC workshop, within one week of the workshop and at 3 month follow-up. The process evaluation was carried out with student midwives from both registration programmes (BSc Midwifery Degree and HDip Midwifery), two focus groups were completed within 2 weeks of attending the ETWBC workshop the purpose of which was to discuss with the students their experiences of the day and the ongoing development of the ETWBC workshop as part of midwifery education.

Confidence

Student midwives' confidence (bereavement support knowledge, bereavement support skill) to provide bereavement care to grieving parents improved following their participation in the ETWBC and this improvement was maintained at 3month follow-up. These results were also supported in the discussions with the student midwives in the focus groups. The results from the study are very positive and demonstrates that the ETWBC impacted on both the level of bereavement care knowledge and skills.

The students' responses, prior to attending the ETWBC, in the open-ended questions about what promotes or inhibits their confidence to provide perinatal bereavement support, and the education they received during lectures on bereavement care was mixed. A number of comments were focused on their lack confidence and minimal exposure, as well as lack of support from senior staff. This lack of confidence was re-iterated in the focus groups. These responses extend previous literature reporting similar lack of confidence in other healthcare professionals dealing with perinatal bereavement support (Puia *et al.*, 2013; Nurse & Price, 2017).

Against the background that the students had received lectures on the key theories and the psychological impact of pregnancy loss and perinatal death, the ETWBC was developed to focus on increasing the students' skills. The content of the ETWBC, especially with the inclusion of the role play, which according to Lendahls *et al.*, (2017), helps students to feel confident and prepared, as well the giving them the opportunity to work in a collaborative group, was developed by an expert group for the study. An important consideration in the development of the ETWBC was that students require the ability to practice hands-on skills in an environment which is non-threatening and supportive, to develop knowledge and competence (Bäck *et al.*, 2017).

Self-awareness

Becoming a reflective, self aware practitioner requires experience (Colligan & Hunt, 2009). This workshop sought to overcome the students' inexperience and lack of exposure by increasing self-awareness and empathy with the use of literature, as recommended by Patterson & Begley (2011), as well as an introduction to the use of reflective journals. Total 'self-awareness' scores increased significantly which was an extremely important and positive result. According to Patterson & Begley (2011), emotional intelligence, which includes competencies such as self awareness and self-confidence, is defined by "our ability to recognise our own feelings and those of others and encompasses managing emotions effectively in ourselves and in our relationships" (pp. 2). This is essential to the process of empathy (Goleman, 1995, cited in Patterson & Begley, 2011, pp.54). The reflective journals were used in the workshop, following recommendations by Colligan & Hunt (2009), who evaluated the use of these journals with students, over a three year period. They found that, prior to the intervention, only one-third of the students had any more than a superficial understanding of critical reflection. Post-intervention, the students' felt that reflection had a continuous positive influence on their practice. It has been suggested that reflective practice for students can contribute to the development of skilled and engaged, as well as self-aware, practitioners (Gallagher *et al.,* 2016). Reflective practice does not only benefit students. Halperin *et al.'s* study, of the effects of stressful childbirth situations on midwives (*2011*), recommend reflective practice for all midwives, in order to empower them, while Bass *et al.* (2017) suggest that reflective practice is regarded as an essential attribute of a competent healthcare professional. Although Goleman, (2004, cited in Patterson & Begley, 2011, pp.54) agrees with Golligan & Hunt (2009) that people learn self-awareness over time, they suggest that it can be enhanced by access to good role-models. Preceptors need to lead by example and nurture emotional intelligence in their students, by approaching mothers and colleagues positively, listening to them attentively and giving productive feedback to students and other colleagues (Goleman, 2004, cited in Patterson & Begley, 2011, pp.57).

Organisational support

Prior to the workshop, there was a relationship between Bereavement knowledge and skills, and students' perceptions of Organisational support, relating to providing bereavement care. There was no relationship between Bereavement knowledge and skills and Organisational support relating to environment or workload at all three time points. The availability and quality of support appeared to be of great importance to the students' during the workshop, however, no changes were made to ongoing organisational support for students and staff, at hospital level around the time, or since the workshop, therefore no increase in the 'organisational support' scale was anticipated. The facilitators of the workshop put great effort into creating a caring, calming environment for the duration of the day. The room had candles and tablecloths and appropriate lighting. The students were given sweets at different intervals, provided blankets for the mindfulness section, and tea and biscuits at the end of the day for the discussion. They were each handed chocolates going home and requested to look after themselves that evening. The students commented on how lovely it was that they were so well looked after and they mentioned being happy that the hospital wants them to "mind themselves". This appreciation was brought up on a number of occasions during the focus groups, implicating the importance of organisational support to the students. With regard to organisational support in general, Halperin *et al.* (2011) recommend formal peer support, and midwife supervision, as well as in-house training on coping mechanisms, after stressful work-related situations, which was thought to promote self-care. Wallbank (2010) agrees with the delivery of clinical supervision, due to the significant reduction in subjective stress levels, burnout and compassion fatigue in the midwives in distress. Keene *et al.* (2010) recommend bereavement

debriefing sessions, allowing staff to reflect on the experience and express their grief. Shorey *et al.* (2017), following their scoping review of the needs of staff facing perinatal death, recommend legitimising the emotional vulnerability of staff; counselling sessions; rotation of staff looking after bereaved parents and providing time for staff to grieve. In an interesting and solution-based article about the concept of a 'Compassionate Hospital,' it was recommended that a sense of purpose and vision is necessary for all hospital staff (Kearsley and Youngsen, 2012). They propose that this well-needed sense of purpose and vision requires clinical leadership to champion this agenda. Midwives and other healthcare practitioners will then take pride in their work and, with the support of the clinical leaders among the staff members, create the cultural change required for a compassionate hospital. This is imperative given the well-recognised link between psychological welfare of staff, and patient (maternal) satisfaction (Kearsley & Youngsen, 2012).

Self Compassion

There was no increase in self-compassion scores, post-workshop or three months later. Although the facilitators used methods hoping to raise awareness of the importance of being a reflective and mindful midwife, as well as re-iterating the importance of self-care, an increase in self-compassion was not achieved. As mentioned in the literature review, there have been some studies evaluating interventions purported to increase self-compassion, in healthcare providers, with mindfulness-based stress reduction interventions being the most common educational technique. A more recent systematic review by Sinclair *et al.*, (2017) critically discussed the latest interventions and came up with slightly different findings to Boelinghaus *et al.*'s 2014 review. The interventions reviewed varied from a 3 day mindfulness workshop (Beaumont *et al.*, 2016) to an 11week 'Embodied Health Course' (Bond *et al.*, 2003, cited in Sinclair *et al.*, 2017, pp.186). Mixed results were reported, with some interventions showing an increase in self-compassion and some not. Interestingly, even programmes of similar content and the same time periods showed conflicting results (Dos Santos *et al.*, 2016, cited in Sinclair *et al.*, 2017, pp.183; Duarte & Pinto-Gouveia, 2016, cited in Sinclair *et al.*, 2017, pp.184). What must be noted is that 3 days was the minimum length of time for any of the interventions mentioned in this review, and the majority of the interventions were 6-8 week programmes. It could be argued that a limitation of the mindfulness section included in the ETWBC was that it only a once-off intervention and a longer programme is needed to yield more effective results. A limitation of the shortest intervention in Sinclair *et al.'s* review – a 3-day workshop, which did show an increase in self-compassion, is that it did not assess participants' self-compassion levels over a longer period of time.

Suggested changes to the workshop

According to the results from the focus groups, role-play had the most significant impact of the day, and there were many positive opinions about the effectiveness of this aspect of the workshop. Many of the amendments to the workshop, recommended by the students, involved increasing time spent on role play, giving the option for more students to participate, and expand the scenarios to include partners and siblings, delivering bad news, as well as watching the experts doing a scenario. These findings are similar to existing research demonstrating the effectiveness of role-playing in bereavement scenarios. Cooper, *et al.* (2012), in their systematic review, highlighted the advantages of simulated learning programs, to increase all midwifery skills. There was a conclusion that, where clinical practice is infrequent, such as perinatal bereavement, simulation can reduce the time taken to achieve competence, and can improve confidence in 'non-technical' skills (Cooper *et al.,* 2012). Although education is essential, as mentioned above, experience can more often predict comfort in delivery of perinatal bereavement care (Bäck *et al.,* 2017; Rondinelli *et al.,* 2015). Role play and simulations are regarded as a high standard second option to experience, for exploring

different communication skills and methods, and come highly recommended by many (Colwell, 2017; Lendhals & Oscarsson, 2017; Meyer *et al.,* 2009; Tobler *et al.,* 2014). Role play was chosen as a teaching method for this workshop because no parent could be harmed or inconvenienced, and the students would not be shamed or feel humiliated, as recommended by Meyer *et al.* (2009). The authors feel that extra time on role-playing, in future workshops, would benefit student's, and indeed staff members, going forward.

'Making memories' was another important component of the workshop, with positive feedback given by the students. As this aspect of bereavement care impacts the emotional adjustment of bereaved parents to such a large extent, the discussion of the many ways in which the students' can assist the parents in the making of these precious memories was of great importance, and very well received. As such, it was deemed essential to keep this element of the workshop unchanged.

Being unsure of what to say or not say was a common fear among this group of student midwives. The component of the workshop discussing this topic, which included the video entitled 'A Letter to my Doctor,' as well as the role-play aimed to reduce the student's fears around communicating with bereaved mothers.' Although some found the video difficult to watch, emotionally, students remarked how informative it was. The few emotional reactions expressed were consistent with those of Hollins Martin *et al.* (2016) whose participants completed the Bereavement Skills Workbook. These students also had mixed feelings about discussing emotional components in a group situation, with some students preferring to avoid this exposure. Overall, however, the authors of this workshop felt that the benefits of the message portrayed in the video far outweigh any emotional discomfort felt, due to the number of comments made, both prior to the workshop and in the qualitative data about being unsure of what to say/not say. This is supported by findings from Fenwick *et al.* (2007) whose qualified midwives in their study had the same concerns and hesitations around caring for bereaved parents, as well as the concerns raised by Mitchell (2004) around the same fear acknowledged by student midwives. For this reason, the authors strongly suggest retaining this as part of the workshop.

As the self-compassion scores did not improve after a mindfulness session, the authors intend to research more effective methods to convey the importance of self-care, including reiterating the possible psychological impact of being a midwife in general, and specifically after dealing with perinatal loss. Helping the students to gain a deeper understanding of the productiveness of reflective journals is also needed. It would have been interesting if the students' were asked, in the 3 month follow-up questionnaire, whether they continued to use their reflective journal. For future workshops, perhaps a shorter length of time could be used for reflection and mindfulness and a more compact self-care class can be developed. This could include statistics on the psychological implications of practice; information on critical reflection; recommended self-care and mindfulness programmes; a list of supports available; and a short, seated meditation. The importance and meaning of self-compassion should also be reiterated as this important concept moderates reactions to potential, and indeed real, failure with the possibility of reducing the adverse effects of events which threaten self-esteem, such as the ones mentioned here (Leary *et al.*, 2007). This possible amendment to the workshop could allow more time for role-play.

A recommendation was made, during one of the focus groups, to increase emphasis on practical skills, such as bathing the baby and running tests, and it was suggested that these skills be practiced on the wards themselves. The authors felt that the responsibility of teaching some of these skills should, in-fact, be taking up by students' preceptors and that more emphasis should be placed on these skills during the students' rotations on the wards. Nevertheless, the request for

more information about tests and post-mortems and what options are available to parents after the baby dies, such as burial, can be included in the workshop.

A number of concerns were raised about inefficient cultural competence and knowledge, in the qualitative data. Students and staff midwives gain exposure to, as well as requiring education on, people from different cultures and religions. The team designing the workshop had requested that a member of the chaplaincy team put together an education piece, for a slot, within the workshop. Unfortunately, due to staff turnover at that time, in that department, they were unable to facilitate this. Therefore, although there was awareness, by the facilitators, that there was a gap in this aspect of knowledge, cultural awareness had to be omitted from the timetable. The importance of being culturally competent and sensitive is repeatedly suggested in the literature (Banovcinova & Maskova, 2014; Bonura *et al.*, 2001; Peng *et al.*, 2012; Walter, 2010). Previous research strengthens the findings of this study, recommending more education on this subject (Attard *et al.*, 2014; Repo *et al.*, 2017). For this reason, the authors suggest that a section about different cultural and spiritual needs, specifically birth and death practices, rituals and wishes, be included in further workshops.

It is acknowledged that a number of suggestions made, in this discussion, involve adding components to the ETWBC. The authors are eager to find the balance between ensuring all of these areas of bereavement care are included into the students' educational curriculum, and not over-loading the students with too much data in one day. There is a commitment to continuous development of the workshop according to these requirements, and indeed future evidence. The next step in improving this workshop, and meeting the needs of students' midwives, in the area of perinatal bereavement, is the meeting of key stakeholders in the collaborating university and hospital to discuss these recommendations. From there, a strategy can be developed to include the more interactive components of the workshop into the updated ETWBC going forward, and to possibly move the more theoretical elements, such as cultural competence and self-care, into the theoretical aspect of the Midwifery curriculum.

6.2 Strengths and Limitations of the study

This study provided valuable information in relation to students' experiences of participating in a workshop on providing bereavement support. A limitation to this study was its small numbers, and that the workshops and study participants were from one unit. Due to the small numbers no comparisons were made between age, experience or educational group. In a larger study, more comparisons can be made. A significant strength of the study, however, is the mixed methods aspect of the data collection and analysis. The qualitative and quantitative data complemented each other and increased the validity of the findings. Although this study had a small number of participants from one Dublin maternity hospital, it was felt that the results can still be generalised to other hospitals, as the 4 year BSc and the 1.5year Higher Diploma courses follow similar curricula. Convenience sampling was felt to be the most appropriate method of sampling for this study, due to the participants we were attempting to recruit. A small number of inclusion and exclusion criteria were drawn up and the research team, with the help of the gatekeeper, insured that only the most suitable students were included in the study.

Accountability and credibility are the key components to ensuring reliability of a study (Braun & Clarke, 2006). The authorship of this study was made up of experts in the fields of education, bereavement, psychology, and midwifery, strengthening the reliability of the execution and the

findings of this research study, as well as the development of the workshop. Additionally, three of the researchers read through the qualitative data and reached a consensus regarding content and themes for the Thematic Network Analysis, as recommended by Braun and Clarke (2006) and Attride-Sterling (2001).

A potential weakness for any questionnaire is that the researcher relies upon the participant to concentrate on each question, remain motivated, and be in the right frame of mind to answer honestly (McLeod, 2001). A limitation of the SCS-Short form, which evaluated the self-compassion, is that the authors of the instrument (Neff, 2003) recommend that it not be broken down into the sub-scales of the original SCS, due to the limited number of questions. However it is advised by Sinclair *et al* (2017) that, in order to analyse the data from the original SCS more accurately, each subscale should be analysed separately, to determine which particular sub-scale of the SCS, such as 'mindfulness' or 'self-kindness', was most impacted by the intervention, if any. For this reason, perhaps the full SCS could have been used, in order to analyse the sub-scales.

Although there was no control group to determine if the increases between T2 and T3 were due to exposure in the clinical area, or due to the intervention, the survey being completed at T2 produced confidence that the increase between T1 and T2 are due to the intervention. Having the questionnaires filled out over time strengthened the findings.

6.3 Implications for Clinical Practice

1. Due to the increase in skills, knowledge, and self awareness, post intervention, it is recommended that all BSc Midwifery and Higher Diploma Midwifery curriculum include such a workshop to increase students' confidence in the delivery of effective bereavement care.

2. The content of this workshop can be utilised in any maternity setting in Ireland and is recommended, not only for the midwifery cohort but to all staff members looking after parents suffering perinatal bereavement or pregnancy loss.

3. More support and encouragement from senior staff is needed to assist the students' in gaining much-needed exposure.

6.4 Implications for Further Research

1. More research is needed to evaluate the confidence of staff midwives after such a workshop.

2. It would also be interesting to evaluate any improvements in care, from the parent's perspective, after a hospital-wide intervention, such as this workshop, compared to the present evidence of inconsistent and sub-standard care reported in the literature.

3. The concepts of self-compassion and self-care require further research, with different interventions being evaluated for their effectiveness.

6.5 Conclusion

To date, education in bereavement support, within the perinatal death and pregnancy loss environment, has been deemed as inconsistent and insufficient. The analysis presented in this report supports the notion that the Education Training Workshop on Bereavement Care (ETWBC) was effective in increasing students' confidence to provide bereavement care and effective in increasing students' self-awareness. For that reason, The ETWBC is recommended as an educational intervention for student midwives. The workshop is not the only intervention recommended assisting the students in gaining more confidence. The results have highlighted that more exposure in clinical practice is needed, and extra support from senior staff and preceptors is paramount to gaining this experience. The workshop was deemed ineffective in increasing students' perception of organisational support and self-compassion. Perhaps the extra support from preceptors to gain exposure, and more emphasis from management on the importance of self-care, such as offering clinical supervision as standard, will increase organisational support. Measures to increase self-compassion require further research. This research provides valuable information for clinical practice and highlights a number of areas for further research.

Chapter 7: Supporting Information

7.1 References

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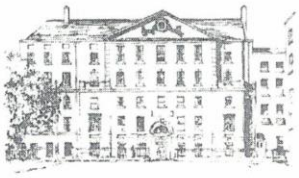
7.3: Appendices

Appendix 1

An tOspidéal Náisiúnta Máithreachais
The National Maternity Hospital
Founded in 1894

Sráid Holles, Baile Átha Cliath 2 • Holles Street, Dublin 2, D02 YH21
Telephone: (01) 6373100. Fax: (01) 6766623. Web: www.nmh.ie

Máistir/Master: Dr. Rhona Mahony



PRIVATE AND CONFIDENTIAL

Ms. Sarah Cullen,
Bereavement Midwife,
The National Maternity Hospital,
Holles Street,
Dublin 2.

16th February 2017

Our ref: **EC 01.2017**

Re: **Bereavement Care Education and Training in Clinical Practice: Supporting the development of competence in 4th year BSc Midwifery and Higher Diploma Midwifery students in the National Maternity Hospital.**

Dear Sarah,

Thank you for your explanatory letter and changes that you have made to this study.

The study has now been approved by the Ethics Committee on Monday 06th February 2017.

Kind regards,
Yours sincerely,

PP. Gayle Reilly
Dr. John Murphy
Chairman,
Ethics Research Committee.

Appendix 2

From: **Exemptions** <exemptions.ethics@ucd.ie>
Date: 21 February 2017 at 11:59
Subject: LS-E-17-25-Coughlan
To: Barbara Coughlan <barbara.coughlan@ucd.ie>

Dear Barbara

Thank you for notifying the Human Research Ethics Committee - Sciences (HREC-LS) of *your declaration* that you are exempt from a full ethical review. Should the nature of your research change and thereby alter your exempt status you will need to submit an application form for full ethical review. Please note for future correspondence regarding this study and its exemption that your Research Ethics Exemption Reference Number (REERN) is: **LS-E-17-25-Coughlan. This exemption from full ethical review is being accepted by the Office of Research Ethics on the condition that you observe the following:**

· **External REC Approval and/or Permission to Access/Recruit Human Participants/or Their Data:** I confirm receipt of evidence that full ethical approval was granted for this project by the National Maternity Hospital Research Ethics Committee, Holles St. Dublin 2.

· **UCD Insurance Requirement:** I confirm that the public liability insurance cover is already in place for this project – no further action is required.

· **Researcher Duty of Care to Participants:** please ensure that ethical best practice is considered and applied to your research projects. You should ensure that participants are aware of what is happening to them and to their data whether a study is de-identified or not. All researchers have a duty of care to their participants who have the right to be informed, the right to consent to participate and the right to withdraw from the study.

· **Data Protection:** Please ensure that you comply with all legal and institutional requirements regarding data protection (including data transfer to and from non-EU jurisdictions), and with the access conditions set by the data controller.

Any additional documentation should be emailed to exemptions.ethics@ucd.ie quoting your assigned reference number (provided above) in the subject line of your email.

Please note that your research does not require a committee review and also note that this is an acknowledgment of your declared exemption status. All Exemptions from Full Review are subject to Research Ethics Compliance Review.

Best regards,

Maciek

Mr Maciej Szydlowski

UCD Research Ethics & Integrity
Roebuck Castle
Belfield
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T: (01) 716 8767
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W:www.ucd.ie/researchethics

Appendix 3

Title: Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in 4th year BSc Midwifery and Higher Diploma Midwifery students in the National Maternity Hospital.

INFORMATION FOR PARTICIPANTS- STUDENT MIDWIVES

You are invited to participate in a Research Project that is explained below.

Thank you for taking the time to read this Information Statement. It is 3 pages long. Please make sure you have all the pages.

Lay title of the Study
Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in Midwifery students in the National Maternity Hospital.

What is the Research Project about?
The loss of a baby or pregnancy has been recognized as a very difficult experience for parents and their families. Improvements in bereavement care have been highlighted as a priority by a number of reports (i.e. CMO Reportinto perinatal deaths in Midland Regional Hospital Portlaoise (Holohan, 2014). Student Midwives have been identified as the group who are in need of support given their novice status and thus limited exposure to care for grieving parents during their midwifery training. Currently there is little information available about the clinical learning experience required by the student midwives to improve their level of expertise in the provision of bereavement care as they advance their training towards working as a Staff Midwife in clinical practice.

The Aim of this study is therefore to improve our understanding in this area by addressing the following 3 questions:

1. What is the Knowledge and the Skills required by Student Midwives (4th Year Internship and Higher Diploma in Midwifery) to deliver effective bereavement care to parents following a pregnancy loss or perinatal death?
2. Does participation in an educational training workshop in bereavement care improve Student Midwives knowledge and skill in this area of practice?
3. Are Self-awareness, Organisational support and Self-Compassion related to Student' Midwives confidence to provide bereavement care to parents following a pregnancy loss or perinatal death?

Who are the Researchers?
Sarah Cullen (Bereavement Midwife, NMH), Brenda Casey (Bereavement Midwife, NMH) Dr Barbara Coughlan (Lecturer and Researcher, UCD). They will also be supported by the Director of Midwifery and Nursing and members of the NMH bereavement research group who will act as advisors during the study.

Why am I being asked to participate in this research project?
You are being asked to participate in this study because you are a student midwife either in 4th year BSc or Higher Diploma Midwifery.

Is there likely to be a benefit to me or will there be potential benefits to improve future medical care?
It is hoped that participation in the educational workshop will provide you with the theoretical knowledge and practical skills to care for bereaved parents.

What will my role be in this Research Project?
Your participation will involve attending a one day educational training workshop (Bereavement Care in Clinical Practice). You will also be asked to complete a questionnaire regarding your confidence to provide midwifery care to bereaved parents at 3 time points, before the workshop, immediately after and 3 months after the workshop. You will also be invited to attend a focus group after the workshop. If more than 8 students agree to participate in the focus group will be randomly drawn from each group.

What are the possible risks, discomforts, side effects or inconveniences?
Owing to the sensitive nature of the workshop, questionnaires and focus groups there is a potential that it may cause some upset or distress. Members of the bereavement team will be available during the workshop should any students need support. A debriefing session will be offered to all students following the workshop. The student advisor in UCD will be informed of the study and will be available for support. Students can also contact the bereavement midwives at any time during or after the study for support and further debriefing can be arranged.

What measures will be taken to ensure confidentiality?
A number of measures will be put in place to ensure confidentiality is maintained during and after the research project. Data will be stored in a locked cabinet, accessed only by the researchers, in a locked office in the NMH. Each student will be allocated an indentifying code which will be stored separately to the questionnaires. This will allow the researchers to match up questionnaires at different time points but maintain your confidentiality. Recordings from the focus groups will be anonymised and stored encrypted on the researcher's password protected laptop. Consent forms will be stored separately to the questionnaires, transcripts and audio-files. All information collected during the study will be safely destroyed by the researchers and after an appropriate time lapse following publication of the research findings.

At the completion of the project, will I be informed of the research outcome?
If you would like to know about the results of the research please let the researchers (Sarah Cullen or Brenda Casey) know.

What will happen with information that is gathered in this study
Findings from the study will be published in Peer-reviewed Journals, presentations will be made at conferences and to the team across National Maternity Hospital.

More Information?
Please feel free to ask for further information before deciding if you will take part. If more information is required please contact:
Sarah Cullen or Brenda Casey. Phone 01-6373225 or email bereavement@nmh.ie

My rights as a Participant

1. The detail of the procedure proposed has also been explained to me, including the anticipated length of time it will take, the frequency with which the procedure will be performed and an indication of any discomfort which may be expected.

2. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to myself.

3. I understand that this research project has been approved by the Research Ethics Committee of the National Maternity Hospital and has received and exemption from the UCD Ethics Committee

4. I have received a copy of this document for my records

Name and phone number of emergency contact (also the person(s) to contact first if you require more information or have any concerns related to the study):

Sarah Cullen and Brenda Casey (Researchers & Bereavement Midwives)
Phone: 01-6373225 Email: bereavement@nmh.ie

Dr Barbara Coughlan (Researcher & Lecturer, UCD)
Phone: 01-716641 Email: Barbara.coughlan@ucd.ie

Appendix 4

Re: **Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in 4th year BSc Midwifery and Higher Diploma Midwifery students in the National Maternity Hospital.**

If you are willing to allow the researcher to contact you to further discuss the research study, 'Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in 4th year BSc Midwifery and Higher Diploma Midwifery students in the National Maternity Hospital'please return this completed form to the researcher in the enclosed stamped addressed envelope. If you are agreeable a member of the research team will email further information about the study.

If you do not wish to participate no further contact will be made by the research team.

Student's name: _____

Phone number _____

Email address _____

I consent for my contact details to be passed onto the research team to allow them to contact me in relation to the research study '

Signed (Student) _____

Printed name_____

Date_____

Or I do not wish to participate in this study and do not wish to be contacted by the researchers.

Student's name: _____

Appendix 5

Title: Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in 4th year BSc Midwifery and Higher Diploma Midwifery students in the National Maternity Hospital.

STANDARD INFORMED CONSENT FOR PATIENT TO GIVE THEIR CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Lay title: Bereavement Care Education and Training in Clinical Practice: Supporting the development of confidence in Midwifery students in the National Maternity Hospital.

Principal investigator(s) Sarah Cullen (Bereavement Midwife, National Maternity Hospital), Brenda Casey (Bereavement Midwife, National Maternity Hospital), Barbara Coughlan (Lecturer and researcher, University College Dublin).

Brief outline of the project incl. benefits, possible risks, inconveniences and discomforts

The loss of a baby or pregnancy has been recognized as a very difficult experience for parents and their families. Student Midwives have been identified as the group who are in need of support given their novice status and thus limited exposure to care for grieving parents during their midwifery training. This study aims to gain a greater understanding of the Knowledge and the Skills required by Student Midwives (4th Year Internship and Higher Diploma in Midwifery) to deliver effective bereavement care to parents following a pregnancy loss or perinatal death and to discover if participation in an educational training workshop in bereavement care improves Student Midwives knowledge and skill in this area of practice
Your participation will involve attending a one day educational workshop (Bereavement Care in Clinical Practice). You will also be asked to complete a questionnaire regarding your confidence to provide midwifery care to bereaved parents at 3 time points, before the workshop, immediately after and 3 months after the workshop. You will also be invited to attend a focus group, which will be audio recorded, after the workshop.

Or if you are a qualified midwife your participation in this study will involve participating in a focus group interview to gain qualified staffs perceptions of student midwives needs in relation to providing bereavement care. This interview will be audio recorded.

I (participants name) _____

voluntarily consent to taking part in this project which was explained to me by
Mr / Ms / Dr _____

I have received an information sheet to keep and I fully understand the purpose, extent and possible effects of my involvement. I understand that I may refuse to consent, or withdraw myself from the study at any time without explanation.

I understand I will receive a copy of this consent form.

Participant's signature _____Date _____

Witness (not a project investigator) _____

Witness signature _____ Date _____

Researcher's signature _____ Date _____

Please return completed consent forms in internal post to the bereavement midwives.

Appendix 6

UCD School of Nursing, Midwifery and Health Systems
UCD Health Sciences Centre,
UniversityCollegeDublin,
Belfield, Dublin 4, Ireland
www.ucd.ie/nmhs

T +353 1 716 6488/6491
F +353 1 716 6450

ScoilnahAltrachta, an ChnáimhseachaisagusnagCórasSláinte UCD
IonadEolaíochtSláinte UCD
AnColáisteOllscoile, BaileÁthaCliath,
Belfield, BaileÁthaCliath 4, Eire

Nursing.midwifery@ucd.ie
www.ucd.ie/nmhs

QUESTIONNAIRES FOR PERINATAL BEREAVEMENT SUPPORT SURVEY

SECTION ONE

DEMOGRAPHIC DETAILS

This section contains questions that will provide information about your background. Please tick the appropriate boxes for the following questions

1. What is your gender?
   Male ☐ Female ☐

2. What is your age in years?
   20-29 ☐ 30-39 ☐ 40- 49 ☐ 50-59 ☐ 60 or above ☐

3. Which midwifery education program are you enrolled in?
   Higher Diploma in Midwifery ☐ c. Midwifery ☐

4. If you are a higher diploma Midwifery student, how long have you been working as a registered nurse prior to commencing the programme?
   Less than 1 year ☐ 1-2 year (s) ☐ 3-4 years ☐ 5-6 years ☐
   7-8 years ☐ 9-10 years ☐ Over 10 years ☐ Not applicable ☐

5. Have you received any perinatal bereavement support education?
   Yes ☐ No ☐

If yes, was it through: formal academic programme, ☐ study day, ☐ OR Other ☐(Please specify)

_____

SECTION TWO

PERINATAL BEREAVEMENT KNOWLEDGE

Listed below are a number of statements. Please read each statement and tick one answer in the box that describes how much you agree with the statement right now.

	STATEMENTS	1 Strongly Disagree	2 Disagree	3 Neither Agree/ Disagree	4 Agree	5 Strongly Agree
2.1	Perinatal loss is a traumatic event for bereaved parents					
2.2	Bereaved parents require the support of midwives to cope with their loss					
2.3	I understand that grieving is a process					
2.4	I know how to provide the specific bereavement support needs of grieving mothers					
2.5	I understand the cultural needs of bereaved parents					
2.6	I understand the social needs of bereaved parents					
2.7	I do not know the legal process associated with perinatal loss before 24 weeks gestation					
2.8	I do not know how to provide the specific bereavement support needs of grieving fathers					
2.9	I understand the religious needs of bereaved parents					
2.10	I know the referral system for					

	additional bereavement support					
2.11	I do not have adequate practical knowledge for bereavement support					
2.12	I know the legal process associated with perinatal loss after 24 weeks gestation					
2.13	I have been well prepared to provide perinatal bereavement support					
2.14	There is a need for continuing perinatal bereavement education for midwives					
2.15	All maternity care professionals at the hospital should receive perinatal bereavement education					

SECTION THREE

SKILLS FOR PROVIDING PERINATAL BEREAVEMENT SUPPORT

Please tick one answer in the box that describes your level of agreement with each of the following statements

	STATEMENTS	1 Strongly Disagree	2 Disagree	3 Neither Agree/ Disagree	4 Agree	5 Strongly Agree
3.1	I have the skills to provide practical support to recently bereaved parents					
3.2	I do not have adequate perinatal bereavement support experience					
3.3	I have grief counselling skills for providing psychological support to bereaved parents					
3.4	I can provide the relevant information required by bereaved parents					
3.5	I can comfortably listen to bereaved parents without trying to interrupt them.					
3.6	I can provide emotional care to bereaved parents					
3.7	I can provide spiritual care to bereaved parents					
3.8	I can easily respond to the needs of bereaved sibling when accompanying their parents					
3.9	I can easily respond to the needs of bereaved parents expecting their next baby					

SECTION FOUR

SELF AWARENESS

Please tick one answer in the box that describes your level of agreement with each of the following statements

	STATEMENTS	1 Strongly Disagree	2 Disagree	3 Neither Agree/ Disagree	4 Agree	5 Strongly Agree
4.1	I am aware of the needs of recently bereaved parents					
4.2	I can easily empathise with grieving parents (Empathy means that I can emotionally put myself in their place)					
4.3	I am conscious of the particular needs of bereaved parents expecting their next baby					
4.4	I am aware of my limitations in relation to the provision of perinatal bereavement support					
4.5	I am aware of my learning needs regarding bereavement support					
4.6	I am regularly engaged in reflective practice in relation to the provision of perinatal bereavement support					
4.7	I am aware of my personal resources for bereavement support					
4.8	Being aware of my need for support in relation to providing care for bereaved parents encourages me to seek help					

SECTION FIVE

ORGANISATIONAL SUPPORT

Please tick one answer in the box that describes your level of agreement with each of the following statements

	STATEMENTS	1 Strongly Disagree	2 Disagree	3 Neither Agree/ Disagree	4 Agree	5 Strongly Agree
5.1	I have support from my workplace management in relation to providing bereavement support					
5.2	I have adequate peer support in my work place in relation to providing bereavement support					
5.3	My work environment allows me to feel relaxed to carry out my daily work					
5.4	I get recognition for providing effective bereavement support					
5.5	The manager organises my daily work placements to facilitate me to provide bereavement support					
5.6	My workload hinders effective bereavement support.					
5.7	There is a clear policy in my ward/unit for the provision of bereavement support to parents					
5.8	There is adequate number of midwives to cover the ward/unit to enable the provision of bereavement support					
5.9	My organisation provides					

	bereavement support training					
5.10	Debriefing opportunities are always provided for me when required following a traumatic incident.					
5.11	I find it difficult to ask for support from my workplace management in relation to providing bereavement support					
5.12	The workload of the ward/unit hinders effective bereavement support					

What other things promote your confidence to provide support to bereaved parents?

_____
_____

What other things inhibit your confidence to provide support to bereaved parents?

_____
_____
_____

If you have other suggestions on how your confidence for providing bereavement support to grieving parents could be promoted, please write them below.

_____
_____
_____

Thank you for taking part in this study.

Appendix 7

SELF-COMPASSION SCALE–Short Form (SCS–SF)

To Whom it May Concern:
Please feel free to use the Self-Compassion Scale – Short Form in your research (12 items instead of 26 items). The short scale has a near perfect correlation with the long scale when examining total scores. We do not recommend using the short form if you are interested in subscale scores, since they're less reliable with the short form. You can e-mail me with any questions you may have. The appropriate reference is listed below.

Best wishes,
Kristin Neff, Ph. D.
e-mail: kristin.neff@mail.utexas.edu

Reference:
Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. Clinical Psychology & Psychotherapy. 18, 250-255.

Coding Key:
Self-Kindness Items: 2, 6
Self-Judgment Items: 11, 12
Common Humanity Items: 5, 10
Isolation Items: 4, 8
Mindfulness Items: 3, 7
Over-identified Items: 1, 9

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a total mean.

SELF-COMPASSION SCALE–Short Form (SCS–SF) 2

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	**2**	**3**	**4**	**5**

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I
am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.