When nurses grieve:

How well are we caring for the carers?

A thesis presented in partial fulfilment
of the requirements of the degree of

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2015
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Originality Declaration

I certify that the content of this Master’s thesis entitled ‘When nurses grieve: How well are we caring for the carers’, is an original piece of work, researched and written by myself. There is no unacknowledged material, with all secondary sources having been fully cited and referenced.

Fiona Rowan
12 June 2015
Abstract

Introduction

All who experience personal bereavement require support to assimilate to the changed reality of living without a loved one. However, unlike the general public, nurses need to do so whilst remaining empathetic and understanding of the concerns of the clients they are caring for – clients who themselves may be experiencing illness, pain, grief or impending death.

Research Question/Aims

This research informs the question: ‘How are nurses supported to work following a personal bereavement experience?’ The study has two primary aims: 1) To establish the extent of existing policy and practice regarding bereavement support for registered nurses (RNs) working in the role of staff nurse in secondary and tertiary healthcare services in New Zealand; 2) To ascertain the experience of RNs in the same practice settings, returning to work following a personal bereavement.

Study Design and Method

This descriptive study utilised a web-based survey to gather responses from two independent groups of participants: Charge Nurses (CNs) and Nurse Managers (NMs) employed within secondary and tertiary healthcare services in New Zealand, with direct team leader responsibility for RNs working in staff nurse roles; RNs working in staff nurse roles within the same practice settings, who experienced a personal bereavement (defined as being the death of a family member, friend or colleague) between eighteen months and five years previously.

Findings

Thirty one eligible responses to a CN/NM survey were received whilst 70 responses informed a RN survey. Study findings reveal four notable themes: The limited organisational policy to assist NMs to support bereaved nurses; The disconnect between NMs perceptions of bereavement support provided, and those of bereaved nurses; The lack of consideration given to the bereaved nurse’s safety to work prior to the recommencement of nursing duties; The incongruity between managerial attitudes and practices in relation to grief and contemporary models of bereavement.
Acknowledgements

Like many Master’s thesis students, I came to this study as a relative research rookie. It is only due to the enormous support of my supervisors, colleagues, friends and family that this thesis is complete and my mental health intact. My gratitude goes to Dr Clare Harvey, Associate Professor, Eastern Institute of Technology (EIT) and principal supervisor, who has guided, motivated and encouraged me at every stage of the study. Clare’s intimate understanding of both the research process and the experience of bereavement, along with her knack of asking probing questions, has helped me to safely negotiate a research journey which has been more than simply an academic task for me. My thanks also go to Mr Alasdair Williamson, associate supervisor, for his attention to detail.

I have been blessed to travel this journey alongside fellow thesis students who have challenged, debated, listened, and enlightened my understanding of research and bereavement. Similarly, I am grateful to my professional colleagues who kept me ‘heading forwards’ with their constant support and encouragement and who assisted in piloting my surveys. To the many nurses from across the country who were ineligible to participate in this research, but who emailed me their stories and expressed their support of this little researched topic, your emails provided an unexpected level of encouragement, and I give you my thanks. Thank you to the nursing and research leaders of the participating DHBs who so kindly assisted me in obtaining locality approvals and to the Directors of Nursing who supported this research in their organisations.

However, my biggest debt of gratitude must go to the participants in this research, without whom this study would be void. It has been my utmost privilege to read of nurses’ experiences of personal bereavement. I have been truly humbled to read of the heart-break, vulnerability and pain of these grieving nurses, but to also see the dedication and resilience that epitomises the strength of spirit of New Zealand nurses. To these wonderful professionals, thank you for your candour. I have been very aware of the responsibility entrusted to me and I trust I have relayed your thoughts, feelings and recommendations with integrity. To the nurse manager participants, thank you for sharing with me the dilemmas you face in clinical practice and providing me with an honest appraisal of your areas of strength and those requiring further development.
Finally, thanks to my remarkable family, Jeff, Matt, Emma, Mum and Dad, you have always been my biggest supporters. I am blessed to have you as my family. Matt and Emma – if your Mum can, so can you!

This research has been inspired by my own experience of personal loss, and is dedicated to the memory of my brother who was tragically killed as a result of the Christchurch earthquake, 22 February 2011: Carey Bird, you are ‘home and free’.
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Chapter 1 Introduction

Background

When considering potential research topics for a Master of Nursing thesis, I sought counsel from a number of acquaintances who are versed in the field of research. I was consistently advised to select a subject in which I had a personal interest, or in which I had a passion to see practice change. This advice helped to clarify my focus, as I recognised that my research topic had in one sense, already chosen me, and that the research journey had started long before undertaking an academic thesis was part of my plan of post-graduate study. Thus the personal experience that has shaped my nursing practice more than any other in the past decade has prompted my research question.

On February 22 2011, the city of Christchurch in New Zealand experienced a cataclysmic earthquake which resulted in the loss of 185 lives, the almost complete loss of infrastructure of our nation’s second largest city, and the devastation of the community emotionally, socially, and economically. Although damage was localised to the region of Canterbury, this event became a national disaster, with an enormous out-pouring of grief and support from across the entire country. One life lost that day, was that of my brother, who died in the hours following the pancaking (collapse) of the office building he was visiting. His death was felt acutely by all members of my family, my elderly parents in particular. Due to the necessary rigorous identification processes, a number of weeks passed before my geographically scattered family could gather for his funeral.

At the time of my loss, I was employed in a dual role as a registered nurse (RN) in a critical care unit and in a small cardiac diagnostic procedures team by a District Health Board (DHB) in a city removed from the destruction in Christchurch. It was my experience that my employer was particularly generous with paid bereavement leave following my loss, with immediate and senior nursing leaders displaying an overwhelming degree of empathy and goodwill towards me during my bereavement leave and upon my eventual return to work.

Disruption to my personal core nursing values

I now recognise that despite the extensive emotional support provided by nursing leaders and colleagues, the care I provided to my patients in those days of grief recovery, was sub-optimal, at best. The set of values and beliefs that underpin professional quality nursing care have
been described as “the 6Cs: care, compassion, competence, communication, courage and commitment” (Cummings & Bennett, 2012, p. 8). Assimilation of these values into nursing practice moves the focus of care delivery from nurse action to patient interaction and from nursing treatment to nursing care (Cummings & Bennett, 2012). Although it was not evident to me at the time, later reflection upon my work experience in the months as life slowly took on a ‘new normal’, made it clear to me that my nursing practice through that period did not consistently reflect any of these essential values. I was distracted, pre-occupied, at times insensitive, and at other times uncaring. I had limited ability to evaluate even the obvious, and my critical analysis skills were more akin to those of a novice nurse, than an experienced nurse of 25 years. As, with great humility and shame, I pondered the care I had provided in the months following my brother’s death, many questions demanded answering: What impact did my fractured psyche have on other team members, on my organisation? Did my failure to provide holistic care go undetected by my nursing colleagues and leaders? Did they experience any barriers in attempting to support me? Given I was working with critically unwell patients, what care had been missed, or mistakes made? To what extent was patient safety compromised? To whom did I fail to offer support? Ultimately, what were the consequences for my patients of this loss of core nursing values?

The impact of a disruption to core nursing values

The significance of these described values in nursing, and the detrimental implications of their betrayal, have been publically witnessed in recent times, through the failure of the Mid Staffordshire National Health Service Trust to provide nursing care that was sensitive to patient needs (Francis, 2013). The public inquiry report highlighted the failure of nurses and nurse leaders to address a prevailing culture of negative values and the failure to promote a “common culture of caring, commitment and compassion” (Francis, 2013, p. 1357). Although the Mid Staffordshire case is an extreme failure of care and is not ubiquitous of either nursing practice or of health care organisations, it has triggered nurses to reflect upon their own practice and how it demonstrates the core values described above (Cummings & Bennett, 2012). I am one such nurse.

Francis (2013) asserts that health care providers have a duty to identify and challenge practices that increase patient risk, and that those in health leadership have an ethical obligation to promote an environment that mitigates this risk as far as is possible. It is this mandate, coupled with reflection on my own experience of working as a RN in a critical care unit immediately following my personal bereavement that has initiated and driven this course of
study. It is my belief that the disruption to my core values following bereavement was such that my ability to provide nursing care reflective of those values was also disrupted. So given the very public and extraordinary circumstances of my bereavement, was my experience unique to me, or did my journey mirror those of other bereaved nurses? Is the disruption of core values I suffered, reflected in the wider body of nurses who have been bereaved?

Anecdotal discussion with other bereaved nurses in the years since has indicated that this may be a common experience, and not one that was exclusive to me.

A nurse’s journey of bereavement

Individuals who are recently bereaved commonly display cognitive, emotional, physiological and behavioural symptoms and signs of grief such as acute sadness, crying, insomnia and a struggle with concentration (Howarth, 2011). All persons experiencing personal bereavement require support to assimilate to the changed reality of living without a loved one (Poole & Giger, 1999). However, unlike the general public, nurses need to do so whilst remaining empathetic and understanding of the concerns of the clients they care for – clients who themselves may be experiencing illness, pain, grief or impending death (Purnell & Mead, 2007). Purnell and Mead (2007) term this intermingling of a nurse’s personal grief with the professional response to her patient’s grief as ‘layered suffering’. This key factor distinguishes bereaved nurses as a unique cohort of the bereaved, separate from that of the general populace. The provision of safe, timely, goal-directed client care demands that the nurse is able to swiftly retrieve tacit and formal knowledge, and to function with advanced observation, analysis and critical thinking skills intact (McCabe & Sambrook, 2013; Pickett, 2009). The nurse must utilise sound judgement and be able to communicate appropriately with patients, whānau (family) and other members of the health care team (Leonard, Graham, & Bonacum, 2004). It stands to reason then, that if the nurse is unable to function at this high level due to a recent bereavement, there may be potential for increased risk to all stakeholders – the patient, the nurse and the employing organisation.

Presenteeism in nursing

This suggestion of potential increased risk to patients when cared for by a nurse who is not functioning optimally, is supported by Letvak, Ruhm and Gupta (2012) who studied the phenomenon of presenteeism in nursing – that is, the practice of nurses being physically present at work whilst unwell. Their research identified an increased rate of medication errors, increased rate of patient falls, and a decrease in quality of care from nurses who were working when ill (Letvak et al., 2012). Alarmingly, they also found that 18% of the 2,500 RNs
studied were clinically depressed and that this was a strong correlate of presenteeism (Letvak et al., 2012).

Key motivators that encourage New Zealand health care providers towards the practice of presenteeism are loyalty to co-workers, to their employing hospital and to their profession (Dew, Keefe, & Small, 2005), all of which may have their roots, in part, in the role socialisation that nurses undergo. On entry to university, student nurses begin the process of role socialisation and are taught to think, act and react like nurses (De Vito-Thomas, 2005). Through the assimilation of nursing theory, academic knowledge and clinical experience nurses take on the persona and identity of a nurse (De Vito-Thomas, 2005). Crout, Chang and Cioffi (2005) opine that it is this very socialisation that fosters presenteeism, as the dominant ‘team culture’ within nursing creates a moral tension for unwell nurses who don’t wish to ‘let the team down’. Furthermore, Crout et al. (2005) found that the tendency towards presenteeism in nursing is inextricably linked with a nurse’s identity which is commonly based upon caring for others, rather than self. In this way, “nurses have been socialized to perceive themselves as subordinates” (Crout et al., 2005, p. 27) and to put their own self-care needs behind those of their clients and their health care team.

These studies begin to describe the factors influencing the phenomenon of presenteeism in nursing. However, they provide little insight regarding the impact of the experience of personal bereavement as a possible additional contributing factor to this practice.

**What is known about the impact of personal bereavement on nurses?**

The literature is quiet regarding the impact of personal bereavement on nurses, and little is known about the attention that the topic of personal bereavement receives either in undergraduate training, or in the workplace setting. Learning to respond to the pain, suffering and mortality of patients is a common thread in training programmes (Supiano & Vaughn-Cole, 2011), and is but one area in which the novice nurse must develop competence. Much has been written in the literature regarding the role of the nurse to support those facing the end-of-life (either their own, or that of a loved one) (Kurian et al., 2014; Pearson, 2010). Similarly, there is a growing body of knowledge regarding the lived experience of the nurse facing the death of a patient (Enns & Gregory, 2007; Gannon & Dowling, 2012). However, there is little primary research to inform how nurses are supported to practice safely and competently following a personal bereavement experience.
Purpose of this research and the research question

Anecdotal evidence elicited from conversations with numerous nurses has indicated that the disruption to core nursing values may be a common experience for those who have suffered a personal bereavement, and not one that was unique to me. These concerning discourses, together with the paucity of nursing research that guides the support of bereaved nurses, have directed the purpose of this study. This research therefore aims to inform the question: ‘How are nurses supported to work following a personal bereavement experience?’ This study has two primary aims:

1. To establish the extent of existing policy and practice regarding bereavement support for RNs working in the role of staff nurse, in secondary and tertiary healthcare services in New Zealand.

2. To ascertain the experience of RNs in the same practice settings, returning to work following a personal bereavement.

Chapter summary

Following the unexpected and traumatic death of a family member, I suffered a significant disruption to the core values that hitherto had underpinned my nursing practice. Despite the best will and intentions of my colleagues and nursing leaders to support me through this time, the care that I provided, was not reflective of professional practice, and ultimately exposed my patients to increased risk. The deleterious impact on health care consumers when these core nursing values are not upheld has been recognised through recent health reports.

It is widely understood that a bereaved individual may suffer from cognitive, emotional, physiological and behavioural effects of grief. However, it is not known to what extent these symptoms may impair a nurse’s ability to remain empathetic towards those being cared for. Similarly, the bearing that an experience of a personal bereavement may have upon a nurse’s critical analysis, decision making and communication skills is unknown. Research has established that the practice of presenteeism in nursing increases the rates of medication errors and patient falls, and results in a decrease in quality of care. The socialisation of nurses into a subordinate role and the assimilation of the nurse identity, that places the needs of others before self, have been described as key factors that foster the practice of presenteeism. Current literature does little to inform nurse leaders about the impact on either the nurse or the patients cared for, when the nurse becomes the bereaved. This research therefore seeks
to take a snapshot of current practice and policy of bereavement support for nurses working in New Zealand, whilst also eliciting the reality of practice for nurses who have worked immediately following a personal bereavement.

The following chapter examines the literature found regarding nurses working following a personal bereavement. The background to bereavement theory and changing models of bereavement practice are also discussed.
Chapter 2 Literature Review

The personal experience of bereavement that has motivated this research project has been described in the introductory chapter. Central to this experience was the detrimental impact of bereavement upon the researcher’s core nursing values, and the resultant failure to deliver patient care reflective of these ideals. Discussion with other bereaved nurses, identified that such a disruption to core nursing values as a result of bereavement may not be unique to the researcher. Personal reflection and discourse with others, have served to clarify the research question – how are nurses supported to work following a personal bereavement experience?

In this chapter, historical and contemporary perspectives of bereavement will be presented, along with an outline of findings from a literature review undertaken on this topic.

**Historical perspectives of bereavement**

“... in this world nothing can be said to be certain, except death and taxes”

Benjamin Franklin (Gigerenzer & Goldstein, 1999, p. 75)

The experience of bereavement is as ubiquitous as life itself. It has been central to the studies, writings and speeches of numerous historical scholars, theologians, philosophers, civic leaders and orators. Each has been influenced by the cultural dynamic and philosophical framework of human understanding of their time (Baltussen, 2012). As early as 45 BC the politician Cicero provided insight into his descent towards depression following the death of his daughter in childbirth and his slow but eventual recovery through engagement in creative writing and reading (Baltussen, 2012). Centuries later, Charles Dickens wrote to his bereaved sister, exhorting her to endure her distressing time of grief – “the disturbed mind and affections, like the tossed sea, seldom calm without an intervening time of confusion and trouble” (Dickens, 1880, p. 2434). These works shaped social perspectives of bereavement, identified grief as a phenomenon to be borne until time resolved, and assisted in the development of the concept of bereavement as being “the sorrow you feel or the state you are in when a relative or close friend dies” (“Bereavement”, 2014, para. 2). The medical profession had little interest in the issue of bereavement, until the publication of Sigmund Freud’s twentieth century theoretical tenets regarding grief, which are considered to be the first major influence upon health professional intervention for the bereaved (C. Hall, 2011). Freud asserted that the resolution of grief demanded a complete cleaving of all emotional bonds between the bereaved and the deceased (Freud, 1917). Only through this ‘trauerarbeit’ or
work of grief, could adjustment to a new reality be realised, new relationships birthed and mental and physical illnesses avoided (Freud, 1917). In health practice, the bereaved individual was therefore exhorted to ‘move on’ from their mourning with expediency, by actively working to confront their loss, and to detach themselves from all memories, images, thoughts of, or connection with the deceased, lest recovery be compromised (C. Hall, 2011).

Some decades later, the face of bereavement care was transformed, by the development of ‘stage’ theories – the most well-known being that of psychiatrist Elizabeth Kübler-Ross (C. Hall, 2011). Based upon her observation of those facing their own death, Kübler-Ross purported that a grieving individual will follow an anticipated, sequential transition through five stages of grief “denial and isolation, anger, bargaining, depression and finally acceptance” (Kübler-Ross, 1969, p. 9). Complications of grief were attributed to the individual’s incomplete journey through one or all of these stages (Kübler-Ross, 1969). This model then developed further to encompass those bereaved by the death of others and formed the basis of undergraduate bereavement training in nursing, medicine, psychology and theology programmes for the latter part of the twentieth century (C. Hall, 2011). Although an attractive model of bereavement, as it sought to infer a degree of order to an otherwise misunderstood experience and promised the ‘nirvana’ of oblivion to the ongoing pain of loss, this theory has been widely discredited (C. Hall, 2011). Critics assert that staged theories have limited application in clinical practice as they fail to traverse cultural, social and gender divides, or to describe the diversity and complexity of individuals’ physical, emotional, spiritual and social bereavement experiences (C. Hall, 2011).

**Contemporary bereavement theory**

Modern bereavement theory has now lain to rest the concepts that grieverers move along a single bereavement trajectory, or that the successful completion of stages will infer acceptance or resolution of grief and the ability to ‘move on’ from one’s loss. Stroebe and Schut’s (1999) Dual Process Model of Grief postulates that the bereaved person dynamically vacillates between two modes of coping, with time spent engaging in each mode being variable, for different individuals, at differing times. When coping in the ‘loss-orientation’ mode, the bereaved’s focus will be on facets of their loss and trying to make sense of what has happened (Stroebe & Schut, 1999). A range of emotional responses will commonly be experienced, including crying, pre-occupation with the deceased, and yearning for the life together that has been cut short. Activities such as perusing photos and seeking locations of special meaning are typical behaviours of this coping mode, as the bereaved person focuses on
their bond with the deceased (Stroebe & Schut, 1999). However, there will be times when the bereaved is more problem-orientated, when the focus of coping is external to the individual and when meaning in life is reconstructed – the ‘restoration-orientation’ mode. In this phase, the bereaved takes ‘time off’ from mourning, looks for and responds to diversions and forms a new identity distinct from that previously moulded when in relationship with the deceased (Stroebe & Schut, 1999). Emotions such as despair, anxiety and pride may all be experienced in this mode, as for example, new skills may need to be learned to undertake the tasks that the deceased had previously been responsible for (Stroebe & Schut, 1999). Engagement in this ‘restoration-orientation’ mode may at times be only momentary, as the bereaved individual responds to fluctuations in energy, life demands, and social norms (C. Hall, 2011).

In contrast to both Freud’s assertion that successful grieving demands that the bereaved ‘let go’ of the deceased, and the common western concept of needing to ‘find closure’ following life-altering events, modern bereavement writers purport that continuing bonds with the deceased can be valuable to the survivor (Worden, 2008). C. Hall (2011) describes this paradigm shift as reflecting the “recognition that death ends a life, not necessarily a relationship” (p. 9). Thus the deceased, although physically absent, may continue to be present in the life of the bereaved in a meaningful and enriching way, acting as a resource to optimise survivor functioning. The survivor’s connection with the deceased is actively maintained, for example through sensing the presence of their loved one or through the maintenance of a social media account. If however, the continuing bond between the survivor and the deceased is based upon an ongoing disbelief in the death, this connection could be seen as maladaptive and unhelpful for the survivor (C. Hall, 2011).

Recent research has found the two distinct processes of sense-making and benefit-finding as being paramount for a bereaved individual’s ongoing wellbeing and successful adjustment to bereavement (Holland, Currier, & Neimeyer, 2006). Sense-making refers to the process by which the bereaved finds a “benign explanation for the seemingly inexplicable experience” (Holland et al., 2006, p. 176), which is frequently reflective of their spiritual, philosophical or secular beliefs. Failure to make sense of the death has been found to be a correlate of complicated grief following a sudden traumatic death and suicide (C. Hall, 2011). Benefit-finding relates to the individual’s ability to find a ‘silver-lining’ from the bereavement experience, and often relates to the imposed development of new skills, an increased sense of family connectedness, or re-ordering of life priorities (Holland et al., 2006).
Search strategy

In order to determine the established knowledge in relation to the topic of bereavement support for nurses, the current literature was reviewed using a systematic search strategy. CINAHL, ProQuest, PubMed, Scopus and Google Scholar databases were examined and the reference lists of retrieved articles were hand searched in order to obtain further relevant studies. Only English language, peer reviewed articles were searched, and the majority were sourced from scholarly journals (the exception to this being four, as yet unpublished theses). No date limits were applied to the searches, as it was deemed to be important to place the topic into a historical context.

Inclusion criteria for this search were primary research that informed the topic of personal bereavement following the death of a loved one, and the bereaved’s experience in returning to work. Initially, the search was restricted to articles describing nurses’ experience of personal bereavement and return to work, however, the paucity of results obtained, required that the inclusion parameter limiting the search to solely nurses’ experiences, be removed. Only articles regarding bereavement as defined by the death of a family member, personal friend or colleague were included in the search. Articles that discussed alternative sources of bereavement, for example bereavement following the death of a patient, as a result of loss of bodily function, survival after traumatic injury, divorce or disintegration/downsizing of organisations and site closure, were excluded. A similar approach was adopted when searching for bereavement or grief policy. Only articles relating to policy about the death of a family member, personal friend or colleague were desired. Therefore, articles pertaining to policy associated with the development or auditing of bereavement or palliative care services, were excluded from the search.

Each database was examined individually and systematically (Appendix 1), utilising Boolean operators (OR, phrase searching and truncation) in a common search order and using the following search terms:

- personal bereavement
- personal grief
- employee bereavement
- employee grief
- bereavement policy
- grief policy
To further refine the large number of articles retrieved from two databases (ProQuest and Google Scholar), the additional search term ‘work’ was applied. Although the term ‘loss’ is commonly one used in everyday language as a synonym for bereavement, when it was added to the search terms, thousands of results that were not relevant to the research question were obtained (including loss of body image, loss of social roles, ageing and retirement). It was therefore necessary to exclude the term ‘loss’ from the literature search.

Based upon the inclusion and exclusion criteria, the retrieved articles were then assessed for relevance by review of either the abstract where supplied, or of the full paper. A summary table of the articles that were deemed to meet the inclusion criteria was completed as each article was retrieved (Appendix 2). All reference data was exported to the bibliographic management tool Endnote.

A total of 14 pieces of primary research were retrieved from the databases using the described strategy. Hand-searching of references did not reveal any further papers for inclusion. It is essential that all articles retrieved from a literature search be critically appraised for merit, validity, relevance and transference of results (Schneider, 2007), prior to inclusion in a literature review. Retrieved articles were therefore reviewed using the Critical Appraisal Skills Programme (CASP) research checklist most appropriate to the methodology of each study (Critical Appraisal Skills Programme, 2013). These standardised frameworks were useful in providing a systematic approach to article analysis, ensuring that the aims, choice of methodology, recruitment strategy, data collection and data analysis were appropriate to the research question and the issues of ethics, potential bias and conflicts of interest were addressed. Through this review process, two studies were found to have no relevance to this topic of research and therefore these were excluded from the literature review.

**Literature search findings**

Analysis of these 12 studies reveals five emergent themes in relation to employee bereavement:

- an overview of the grief response
- the impact of grief upon the ability to work
- the impact of the work environment and culture upon the employee’s experience of grief in the workplace
- the role of the immediate team leader
- the role of the organisation
An overview of the grief response

As the focus of the literature search was to retrieve articles specifically informing the subject of the impact of bereavement on the ability to work and policy relating to bereavement support for employees, an analysis of the entire experience of bereavement of grieving individuals was not envisioned. Undoubtedly, altered search terms would procure a wealth of literature about this phenomenon. However, this literature search has provided interesting insights into the nature of the grief response, specific to those returning to work immediately following bereavement. It has been found that bereaved employees experience a fluctuating nature to their grief experience, which may last for a number of years (Crookes, 1996; D. Hall, Shucksmith, & Russell, 2013). A discussion presented by Broadbent (2013) regarding the impact of the death of a loved one upon the bereaved’s sense of self, and of the need to relearn their sense of self in the absence their loved one, highlights the inner confusion of some bereaved and the journey that is necessary to find healing post bereavement. Trimble (2010) provides an in-depth description of the interplay between financial, social, domestic and work implications for the bereaved employee, with disruption in one realm having direct effect upon another (for example, the need to reduce work hours due to new childcare responsibilities resulting in flow-on financial implications). Trimble (2010) also provides concerning evidence regarding the use of medication and alcohol amongst the bereaved as a tool to assist with sleep and anxiety issues, although the extent of the use of these coping mechanisms is not clear. Other reported stressors related to the grief experience included reduced social contact secondary to the death of the primary social facilitator in the relationship, the perception of the need to ‘hide’ grief in order to protect others from the impact of that grief, the loss of routine and the necessity to take on new roles and responsibilities (Trimble, 2010).

The impact of grief upon the ability to work

Thirty four organisations were surveyed by McGuinness (2009), who found that 94% of employers believed an employee’s work performance could be affected by personal bereavement, whilst 62% understood that there were, or could be, health and safety implications for the employee and/or the organisation. Newly bereaved employees reported being overwhelmed by work demands, feelings of diminished competence, the inability to cease crying at work and 62% reported a struggle to concentrate and make even menial decisions (D. Hall et al., 2013; Trimble, 2010). These findings add weight to those of Ripps (1992), who found that 68% of bereaved employees surveyed felt their work performance was adversely affected at one month following their bereavement, 44% at three months, and 33%
still felt they had diminished work productivity at six months post bereavement. The therapists interviewed in Broadbent’s (2013) research reported that one key to maintaining safety in professional clinical practice following personal bereavement, was the undertaking of both personal and professional development. These therapists also uniformly reported that the experience of personal bereavement and the journey to find healing had a long-term positive influence upon their professional practice, particularly in the realm of increased empathy and connectedness with bereaved clients.

**The impact of the work environment and culture upon the employee’s experience of grief in the workplace**

A number of studies reported the noteworthy impact that colleagues have on the bereaved person returning to work. According to Hazen (2003), colleagues and work relationships can be either a contributing factor to, or a detracting factor from the process of healing after a loss. DeLeon (2007) discusses how a culture of compassion within the workplace, can itself be a source of support for the bereaved employee. Acts of kindness, sensitivity and taking some of the bereaved’s workload were identified as being helpful strategies displayed by co-workers (Gibson, Gallagher, & Jenkins, 2010). Conversely, certain collegial behaviours, such as making insensitive comments, flippant remarks regarding death, talk about suicide and perceived avoidance were reported as being unhelpful (Gibson et al., 2010; Ripps, 1992). For some, work became a safe place to focus on matters other than their grief, and became a useful facilitator of healing (Eytemsinian, 1998; Gibson et al., 2010; D. Hall et al., 2013). Some study participants suggested that education, informed by survivors’ experiences, be provided for all workers, in order to understand how to respond more helpfully to hurting co-workers (Gibson et al., 2010; Ripps, 1992).

**The role of the immediate team leader**

Studies showed the emergence of the role of the team leader as a key feature in the success of the bereaved employee’s return to work. D. Hall et al. (2013) describe bereaved employees remembering the exact phraseology used by managerial staff, even years after the event, such was the manager’s influence upon the psyche of the grieving worker. Both Gibson (2010) and DeLeon (2007) found that a team leader taking a blanket approach to bereavement care and displaying ignorance of the bereaved individual’s personal difficulties was unhelpful. Some grieving workers described their team leader expecting a return to full productivity upon immediate re-commencement of work (Gibson et al., 2010). Others felt their manager expected them to cope with challenging tasks as if nothing had changed in them, whilst others reported feeling bullied and challenged by supervisors (Gibson et al., 2010; Ripps, 1992).
More helpful practices, such as taking a personalised approach to the employee (DeLeon, 2007; D. Hall et al., 2013; Ripps, 1992), understanding the personal impact upon, and responding to employee grief (Gibson et al., 2010; Maxim & Mackavey, 2005; Trimble, 2010), and regularly asking the employee how they are (DeLeon, 2007; Trimble, 2010) were found to be important in facilitating a return to productive work. Research showed that in many instances, initial support from the team leader was respectful of the employee’s circumstances, but that this support tended to ebb over time (D. Hall et al., 2013; McGuinness, 2009).

When McGuinness (2009) researched 34 Irish places of work, including large and small, public, private and local government organisations, he found that the experience of employee bereavement within the previous 12 months was universal to them all. Yet Maxim and Mackavey (2005) found that none of the leaders in the 34 organisations they surveyed had ever received any type of bereavement training. The need for employer education with regard to the bereavement care of workers was also supported by DeLeon (2007) and Trimble (2010). Maxim and Mackavey (2005) further provide interesting insight into the moral dilemma faced by managers, who generally desire to ‘do their best by’ their bereaved employee, whilst continuing to juggle (the at times increased work-load of) co-workers and productivity targets.

**The role of the organisation**

Paralleling the lack of employer education regarding employee bereavement, McGuinness (2009) found that 88% of the organisations surveyed had no formalised bereavement policy to guide management teams, despite an acknowledged 100% experience of employee bereavement in the past year. Where policy had been established, there was variability in interpretation of policy documents (even within the same service or organisation) and instances of the policy being used in unintended ways (D. Hall et al., 2013).

In relation to the time taken off work, many employees anticipated the autonomy to be self-determining in their care of themselves and their family, and expected work structures to accommodate a phased return to work, with innate flexibility to allow for this (Gibson et al., 2010; Maxim & Mackavey, 2005). However, in reality, it was the employing organisation which largely controlled this process, with the majority allowing between two and five days paid compassionate leave (D. Hall et al., 2013; Maxim & Mackavey, 2005; Trimble, 2010). Trimble (2010) found that 93% of bereaved workers stated a need for longer than five days paid leave, and as many as 44% took an increased amount of sick leave (between two days and six weeks).
in the ensuing weeks following bereavement (McGuinness, 2009; Ripps, 1992; Trimble, 2010).
It is important to note Eyetsemitan’s (1998) findings, that half of those surveyed described their attachment to the deceased as either ‘strong’ or ‘very strong’ and that the importance of this attachment did not necessarily translate to either their close biological relationship to the deceased, or to the amount of compassionate leave approved by management. Thus, the loss of a first-generation family member (for example, death of an elderly parent), was deemed to be of greater importance and impact upon the bereaved individual, than the sudden death of a close friend. D. Hall et al. (2013) also found this concept of a ‘sliding scale’ of bereavement, whereby the manager’s perception of the bereaved’s closeness to the deceased, was a more important element in influencing the support offered to a bereaved employee, than the employee’s actual intimacy with the deceased. Other factors described as influencing this ‘sliding scale’ of bereavement include the manager’s own values and experience with regard to death, family and community and their perception of the employee’s commitment to the organisation (D. Hall et al., 2013).

It is also interesting to note, that despite a common desire for increased paid bereavement leave (DeLeon, 2007; Eyetsemitan, 1998; Trimble, 2010), other factors were deemed to be more important with regard to the organisational response to employee bereavement. Areas identified as being key, include the removal of expectations that the bereaved employee can and will function at full capacity, allowing instead, for a temporary change in productivity (DeLeon, 2007; Ripps, 1992). Eyetsemitan (1998) found that 84% of employees reported the resumption of full responsibilities immediately upon return to work. Similarly, the provision of flexible return to work options were seen as important, but only 38% of workers were offered these (McGuinness, 2009).

The need for the provision of bereavement resources and facilitated access to professional counselling (preferably on-site) was commonly described by study participants (DeLeon, 2007; Eyetsemitan, 1998; Ripps, 1992). DeLeon (2007) discovered that 85% of bereaved employees were not made aware of resources available to help during the grief recovery period, and this was within an organisation that paid for the services of an Employee Assistance Programme (EAP). Similarly, Gibson et al. (2010) state that none of those they interviewed were offered any help to find support, and none of the bereaved felt they got the support they needed. Gibson et al. (2010) suggest that a key role of the organisation is to assist the bereaved employee to find appropriate counselling and support from qualified professionals if required. They suggest this could be achieved by the nomination of a dedicated person within the organisation whose role it is to have an understanding of local and national bereavement
support networks. Naidoo and Delport (2009) indicate that 94% of respondents to their research, felt they would have benefited from a bereavement programme facilitated within their workplace.

Another key role of the organisation highlighted in research, is the provision of survivor-informed bereavement training for team leaders and managers in order to more effectively respond to employee needs (DeLeon, 2007; Gibson et al., 2010; Ripps, 1992). D. Hall et al. (2013) identified that although some organisations displayed a good understanding of employee bereavement, others did not realise the negative impact on their service associated with poor management of grieving workers, such as increased sick leave, absences and low morale.

**Gaps within research**

Despite the wealth of knowledge gained through these research projects, gaps within current literature are noted. Only one study retrieved (Crookes, 1996) directly relates to nursing, and this provides a historical rather than a contemporary overview of bereavement care in nursing practice.

Crookes (1996) found that nurses are prone to experiencing delayed onset of grief and chronic grief. This experience of complicated bereavement, was found to be associated in part with the societal expectations that the nurse-relative will become the ‘family nurse’ (Crookes, 1996). In this role, the bereaved relative, who happens to be a nurse, is expected to use their health experience to interpret health information for family members, to direct care and to support other grieving relatives. Crookes (1996) also argues that this propensity for nurses towards complicated grief following personal bereavement may be due to the process of acculturation, whereby nurses, through formal and informal training, become independent ‘copers’, who inherently find difficulty in asking for help.

Although the results of Crookes’ (1996) study highlight significant issues that paint a historical picture of nurses’ experience of personal bereavement, they do not necessarily reflect the journeys of bereaved nurses in contemporary practice. Changes to two essential features of nursing practice since Crookes’ (1996) study have implications upon bereavement care for today’s nurses. The first element is that of the nurse’s professional identity – that is, the way in which a nurse thinks and feels about her/himself as a nurse and the perceived value the nurse places on their role (Johnson, Cowin, Wilson, & Young, 2012). Influences on the professional identity of a nurse include the healthcare environment, the educational curricula.
of nurse training and societal perceptions of the role and value of nursing (Johnson et al., 2012). In the past few decades, the professional identity of nurses has been impacted by their adaptation to an increasingly technologically diverse health care environment and their adoption of expanded practice roles that demand greater technical proficiency than in years past (Johnson et al., 2012). Similarly the changes to nursing education, with undergraduate and post-graduate training being more embedded in academia have likely impacted on a nurse’s professional identity (Johnson et al., 2012). A further modifying influence in this regard is that of societal perceptions of the value of the nursing role which have shifted as medical knowledge has become globally accessible to the public (Johnson et al., 2012). Thus changes to professional identity of nurses could have impact upon their experience of bereavement care and of working following a personal bereavement.

The second feature of nursing practice that has changed since Crookes undertook his research is the degree to which nurses engage in emotional labour in practice. Consistent with the definition of Hochschild (1983), emotional labour in nursing is the work undertaken by a nurse to promote in their client a sense of wellbeing and of being cared for. This caring function of emotional work is considered as essential to nursing as other skills, such as critical thinking or time management (Smith & Gray, 2001). However, researchers have found that changing healthcare environments, in which nurses must accommodate an increasing patient throughput with decreasing capacity and resource (a concept termed work intensification) as being the primary adverse influence upon standards of care in nursing (Cooke, 2006). Thus in a work milieu of increased workload, nurses have a decreased ability to engage in emotional labour, and this, in turn is likely to impact upon both their professional identity and their experience of working following a personal bereavement. Similarly, the business leadership structures of healthcare providers and the increased financial and organisational responsibilities of the contemporary NM (Quin, 2009) creates decreased capacity for NMs to engage in emotional labour with their grieving team members (Jackson, Hutchinson, Peters, Luck, & Saltman, 2013).

Thus, whilst providing valuable background, Crookes’ (1996) historical research is insufficient to inform a contemporary discussion regarding either bereavement care for nurses today or of their experience of working following bereavement. This gap in recent nursing literature therefore supports research that places this topic into a current context.

Additionally, the literature review not only highlighted a gap within current literature in relation to bereavement care specific to the nursing workforce, it also identified that none of
the studies retrieved were generated in the New Zealand healthcare environment. The majority of the studies reviewed were undertaken in the United Kingdom, the Republic of Ireland and North America. It is postulated that New Zealand nurses may have differing experiences of bereavement care from nurses of other nations, due to national legislature and recent immigration policy.

Unlike New Zealand, the countries from which the majority of these studies originated do not have national or state legislation that mandates bereavement leave entitlement for employees. In the United Kingdom, bereaved workers are permitted a ‘reasonable’ amount of time off after a crisis involving a dependant (Gov.UK, 2013), with interpretation of this legislation being left to the employer. In the United States of America, the Fair Labor Standards Act (1938) does not provide for paid bereavement leave, and any entitlement to this is part of an individual’s negotiated contract with their employer (JustAnswer, 2014). Similarly, in the Republic of Ireland where McGuinness undertook research, there is no central government mandate regarding bereavement leave entitlement (paid or otherwise) and is dependent on the individual’s employment contract (Citizens Information, 2014). Thus research originating from these countries, fails to inform the climate of bereavement leave in New Zealand.

Further differentiating New Zealand nurses as a particular cohort and therefore worthy of specific research, are New Zealand’s immigration policies since late last century, which have resulted in a high rate of new migrant settlement vis-à-vis other countries (Singham, 2006). The joint paper presented by the Organisation for Economic Co-operation and Development (OECD) and the World Health Organisation (Zurn & Dumont, 2008), outlines that New Zealand DHBs responded to the concurrent nursing shortage by adopting a purposeful global recruitment policy. The intention was to persuade international RNs to move to New Zealand to supplement the domestically-trained nursing workforce. As a result, the New Zealand nursing workforce has a greater and more diverse international dimension than other OECD countries (Zurn & Dumont, 2008). Current Nursing Council of New Zealand statistics reflect this trend, with over 25% of RNs in New Zealand identifying with an ethnicity other than Pākehā (New Zealand European) or New Zealand Māori (Nursing Council of New Zealand, 2014). It is understood that the very act of migration and settling in an alien society, is a significant stressor as migrants are geographically removed from their country of origin, are isolated from extended family and established supports and have their cultural identity challenged (Bhugra & Becker, 2005). Immigrants are prone to experiencing ‘cultural bereavement’, a grief response resulting from the loss of social norms, religious practices and
culture and may experience an increased propensity towards mental health illnesses (Bhugra & Becker, 2005). When migration is involuntary, as with refugees and asylum seekers, these risks are compounded (Bhugra & Becker, 2005). It is therefore possible that this experience of migration and cultural bereavement could be a negative moderator upon the New Zealand migrant nurse’s personal bereavement journey.

Furthermore, this cultural diversity is also likely to present management challenges that differ from those experienced in other countries – challenges that demand an approach that is sympathetic and responsive to the individual needs of employees (Singham, 2006). Exactly what these challenges are, especially in relation to bereavement support for nurses, are as yet unknown.

This literature review has evidenced a dearth of nursing-specific, New Zealand-based studies. This finding therefore validates the need for further research that places a current perspective upon the issue of how nurses are supported to work in New Zealand hospitals following a personal bereavement.

Chapter summary

Only one study has been undertaken within the profession of nursing (Crookes, 1996), and although this study is useful for painting a historical picture of the experience of personal bereavement for nurses, it does little to inform nurse leaders about current practice or organisational culture. None of the studies found were conducted in New Zealand. The majority of research has come out of the United Kingdom, the Republic of Ireland, the United States of America and Canada. As discussed, unlike New Zealand, employers in many of these countries are not governed by national bereavement legislature that mandates minimum employee entitlements following bereavement. New Zealand nurses represent a greater and more ethnically diverse workforce than seen in other countries, and this is likely to create further challenges to employers caring for those who have been bereaved.

Thus, further study into the current policy and practice surrounding bereavement support for nurses and an exploration of nurses’ experiences of working following a personal bereavement, is justified. It is imperative that this research be conducted within a New Zealand nursing framework, where findings will reflect the political, social and cultural influences in our nation.
In the next chapter the research methodology will be outlined, including the sampling method, data collection tool, data collection procedure, ethical considerations, data processing and analysis.
Chapter 3 Methodology

As previously outlined, reflection upon my own nursing practice following the traumatic death of my brother and anecdotal conversations with bereaved colleagues, has led me to ponder the issue of bereavement support for nurses. These musings gelled into the research question for this study: ‘How are nurses supported to work following a personal bereavement experience?’ The preceding literature review chapter presents historical and contemporary perceptions of bereavement and highlights the gaps in current research regarding the phenomenon of personal bereavement/bereavement support for New Zealand nurses. Only one historical study directly relating to nurses’ experience (Crookes, 1996) was retrieved. Whilst Crookes’ (1996) research is invaluable in describing a historical perspective of the issues faced by bereaved nurses, the current socio-political healthcare environment (Quin, 2009) and shifting professional identity for nurses, is likely to have altered the nature of a nurse’s personal bereavement experience. Thus a study placing nurses’ experience within a contemporary New Zealand context and highlighting enablers and barriers to bereaved nurses working in acute healthcare would be of value.

This methodology chapter links the research question and the literature review to the descriptive research framework employed in this study. The choice of a mixed method survey design that includes both quantitative elements and qualitative explanatory comments and free-text questions is now discussed. Furthermore, the sampling methodology including participant selection and recruitment, data collection tools, data collection procedure, ethical considerations, data processing and analysis methods are presented.

Research framework

The absence of existing research describing the variables affecting bereavement support for nurses, informed the choice of research framework utilised for this study and allowed that consideration be given to a wide range of perspectives for inclusion in the study. In such circumstances, Elliott and Thompson (2007) indicate the establishment of a base-line snapshot of existing policy and practice that identifies, explores and measures the variables influencing the topic, as being an important focus of initial study. In line with LoBiondo-Wood and Haber’s (2010) suggestion that descriptive studies are appropriate for providing a knowledge base for a previously unstudied, or little studied phenomenon, a mixed method research approach was chosen, employing a descriptive survey design.
Congruent with this framework of study, no attempt will be made to identify relationships between variables or determine causality as suggested by Elliott & Thompson (2007). Along with the relative superficiality of findings compared with other research methodology, the lack of relationship between variables is a recognised limitation of this research framework (Elliott & Thompson, 2007). However, it is believed that the identification of common characteristics and practice through this descriptive study, will lay the foundation for future, more in-depth research on this topic.

Whilst acknowledging the limitations of this research methodology, there are theoretical and practical advantages inherent in utilising surveys for this research: The relative ease of data collection in terms of time and financial constraints (Elliott & Thompson, 2007); the ability to capture a significant amount of data from geographically diverse communities of nurses to establish a national snapshot (Elliott & Thompson, 2007); the resources required are appropriate to the Master’s level of study for which this research is being undertaken.

As the subject is highly personal, there is substantial knowledge to be gained by exploring this topic as a lived phenomenon, eliciting nurses’ subjective perceptions and feelings through their own words, regarding their experience of working through the grief recovery phase, and of the dilemmas faced by their nursing managers. For this reason, qualitative elements were added to survey designs (open questions and free-text boxes) in order to capture opinion and belief and to highlight existing values, employment and professional cultures from the nurses’ perspectives. Thus the mixed method surveys are an appropriate framework to explore the topic being researched.

**Sampling methodology**

In order to gain a comprehensive answer to the research question, insight into this topic from both the bereaved RN’s perspective, and from those who routinely offer the support to the bereaved nurse, the nurse’s charge nurse or nurse manager (henceforth referred to collectively as managers, nurse leaders or nurse managers (NMs)), was sought. Thus two separate cohorts of respondents were questioned, using different survey instruments, with both perspectives presented and discussed.

As indicated, the research question has informed the choice of research design and together they have informed the sampling strategy. This affords a clear transition through the research process in keeping with the recommendations of Elliott and Schneider (2007). Sampling NMs regarding their experience of supporting bereaved RNs, required that locality approval from
each of the NMs employing organisations be obtained (this process is discussed in greater depth presently). To undertake this at a national level would be prohibitive in terms of available resources, and thus a non-probability, purposive sampling method was employed. This sampling strategy is supported by Schneider and Elliott (2007) who indicate that a non-probability sampling method is appropriate for small studies of this nature. Based upon known characteristics of the 20 New Zealand DHBs, three were non-randomly identified as a representative sample. An attempt was made to include secondary and tertiary care DHBs (that is, those hospitals offering consultative and/or technically advanced specialist care) and DHBs of varying sizes in the sample group. One DHB was avoided, as it is centred in the region devastated by the 2011 earthquake prompting this course of research. Due to the significant loss of life, and the cataclysmic disruption to all essential services from this earthquake, it is thought that the experience of bereavement support in this region would not be reflective of a national perspective. A request for approval to conduct the research within one of the selected DHBs was unsuccessful, therefore an alternative DHB was approached and approval gained.

It was a natural step to then employ the same sampling strategy for the RN survey, recruiting participants via the three DHBs, thus enabling data to be more useful to the participating organisations. In choosing a non-probability purposive sampling methodology, limitations are recognised. There is no expectation that all elements pertinent to the research question will be captured however, it is believed that with a sufficient sample size, over- or under-representation will be minimised (Schneider & Elliott, 2007). It is also understood that findings from research using this sampling methodology, have limited generalisability to other population groups, given the hand-picked nature of the sample group (Schneider & Elliott, 2007). To ameliorate these issues, and to increase sample size, the survey link for the RN survey was also disseminated via the Facebook pages of the New Zealand Nurses Organisation (NZNO) and the academic institution supporting this research. The further strategy of snowballing was also utilised for the RN survey. In this way, nurses exposed to the research within the chosen sample groups, were invited to forward survey information and link to others in their network – nurses of their acquaintance, whom they thought may be interested in participating (Whitehead & Annells, 2007). The numbers of New Zealand nurses who have experienced a personal bereavement between 18 months and five years ago is unknown and unavailable and therefore the potential sample size is unknown.
Inclusion and exclusion criteria

Inclusion and exclusion criteria for the two cohorts of participants were considered:

1. Registered nurse participants.

Inclusion criteria: Nurses employed in the role of staff nurse at the time of their bereavement in a New Zealand secondary or tertiary healthcare organisation, who had experienced the death of a loved one (family member, friend or colleague) between 18 months and five years previously, were invited to participate.

Exclusion criteria: Anecdotal conversation with nurses would indicate that nurses in senior roles (for example clinical nurse specialist, nurse educator) may have a different experience of working following a personal bereavement, from RNs employed as staff nurses. Discussions with senior nurses indicated that these more autonomous roles enabled them to manage their own needs, and that the organisation’s requirement to ‘back fill’ any leave may not be felt as acutely as for nurses in staff nurse roles. For this reason, and given that nurses in staff nurse (or equivalent) positions represent approximately 85% of the registered nursing workforce employed in New Zealand DHBs (Ryall, 2014), it was decided to limit the research field to RNs working in a staff nurse capacity only. Nurses experiencing bereavement within the past 18 months were asked not to participate. As discussed in the previous chapter, the majority of bereaved people slowly assimilate the loss of their loved one, coming to a place where the intensity of grief reactions have decreased, allowing the sufferer to adapt to a ‘new normal’ (C. Hall, 2011). Despite no two bereavement journeys being the same, research has shown that for most, this adaptation takes approximately six months, although this by no means equates to a resolution of grief (C. Hall, 2011). However, for the group of the bereaved (10-15%) who experience prolonged grief disorder, debilitating grief symptoms will be present for a protracted time, impacting significantly upon their ability to cope with routine life demands (C. Hall, 2011). As nurses have a propensity towards complicated grief (Crookes, 1996) and due to the potential to exacerbate these already weighty grief reactions in nurses who may be experiencing protracted grief, a minimum time-frame of 18 months was set, so as to decrease the potential for further psychological harm to these nurses. Nurses bereaved longer than five years previously were also asked not to participate, as a contemporary rather than a historical picture of bereavement support for nurses was being sought. Additionally, those not employed at the time of their loss and those experiencing bereavement related to loss of function, role, relationship (e.g. divorce), redundancy, death of a patient/client, illness or loss of a pet, were asked not to participate.
2. Nurse manager participants.  
Inclusion criteria: Nurse managers (NM) working in secondary or tertiary healthcare in New Zealand, with immediate team leader responsibility for RNs working in staff nurse roles, were asked to participate. There were no exclusion criteria for this cohort.

**Data collection tools**

Based upon themes revealed in the literature search, two questionnaires (Appendices 3 and 4) were developed in order to collect research data. As this study was being conducted amongst a cohort of professionals who commonly use written reports in their daily practice, questionnaires requiring respondent’s to have proficient literacy skills was not seen as a barrier. Both questionnaires utilised a four-choice Likert scale asking respondents about the extent to which they agreed or disagreed with given statements. Option was given to provide further depth with explanatory notes on many questions, whilst other questions allowed only free text responses. There is ongoing debate regarding the most appropriate number of items to be used on a Likert scale, with both uneven and even scales having advantages and disadvantages in differing research settings and with differing cohorts of participants (Losby & Wetmore, 2012). A four-point Likert scale was chosen for this research, as it forces the respondent to formulate an opinion on the topic (Krostoulas, 2013). This strategy is appropriate when researching matters that participants have personal experience of, and are likely to therefore have opinion on, even if that opinion has not previously been articulated (Krostoulas, 2013). The absence of the neutral central option also decreases respondents’ propensity towards central tendency bias, the habit of scoring a question close to the scale’s midpoint and avoiding the recording of potentially controversial extreme opinions. Moreover, the use of a four-point scale eliminates potential confusion and ambiguity over the meaning and interpretation of the neutral, central option found on uneven-item scales (Losby & Wetmore, 2012). Regardless of careful labelling by the researcher of the central option, Losby and Wetmore (2012) assert that respondents will attribute their own meaning to this, depending on their views. In this way, the neutral option could be taken to mean ‘neither agree nor disagree’, ‘equally agree and disagree’, ‘no opinion’, ‘uncertain’, ‘do not know’, ‘not prepared to answer’ or even ‘not interested’, all of which mean different things, complicate analysis and decrease data validity (Losby & Wetmore, 2012).

Reliability and validity of the data collection tools were assessed through conducting two pilot studies. Five NMs with responsibility for leading teams of RNs and five RNs, who have experienced a personal bereavement, were asked to participate in the pilot studies. The
responses from these nurses indicated that the tools were easy to understand and negotiate, that questions were asked with clarity and enough space was provided for responses to free-text questions. Responses were evaluated to ascertain if the information obtained answered the research question. Only one change was made as a result of feedback from the pilot studies. In the NM pilot, participants were asked to respond using the Likert scale to the statement, “I do not feel comfortable supporting RNs who have experienced personal bereavement”. One charge nurse responded that supporting a bereaved colleague was never a ‘comfortable’ experience, regardless of the degree of skill of the NM. The word ‘comfortable’ was therefore substituted with ‘confident’ which was more likely to elicit the desired information.

**Data collection process**

The approvals process to undertake this research was commenced in June 2014 and took four months to complete. Requests for academic and ethical approvals and consent to access the research population (Appendices 5 to 10) were sought and gained from:

- EIT Faculty Academic Committee
- EIT Research Ethics Approvals Committee
  
  As this research did not involve health consumers, the collection and storage of human tissue, and did not expose participants to risk of physical or psychological harm greater than would be expected in daily living, Health and Disability Ethics Committee (HDEC) approval was not required.
- *Kaumātua (Māori elder) Group and Māori Health Unit in the DHB in which the researcher is employed*
- Locality approval from each of the three participating DHBs.
- NZNO Research Section Chair and Media Advisor

Once approvals were obtained, the Director of Nursing of each participating DHB, or their nominated research officer, was emailed with a request to disseminate survey links and to endorse the research if they were comfortable to do so. Two information letters, one for potential NM and another for potential RN respondents (page one of appendices 3 and 4), were then emailed in reply, for forwarding to their nursing staff. These letters included the following information:

- Identification of the researcher as a Master of Nursing student completing a research project
At the time of request for assistance with survey link dissemination, an additional request for the number of potential NM respondents was made, for later use during data analysis.

The same information for the RN survey was presented in a poster format to the Chair of the NZNO Nursing Research Section as well as the NZNO Media Advisor, with the request that it be uploaded to the NZNO Facebook page. Additionally, the research principal supervisor made arrangements to have the RN survey information and link uploaded to the EIT Facebook page.

Data were collected for both surveys for a period of six weeks, from October 7, 2014. The online survey provider Survey Monkey was utilised for this process. The use of a web-based format was seen as being appropriate as informatics (information technology) skills are now obligatory for all nurses, due to the increasing global usage of electronic patient records (Hwang & Park, 2011), communication and educational tools. Nurses in New Zealand are no exception. Additionally, email is each of the participating DHBs’ preferred mode of communication with their staff. The use of this on-line format also provided an added level of assurance to the participants regarding the anonymity, confidentiality and safe storage of their responses, as no identifying characteristics of individual participants or their employing DHBs was known, and data were accessible only to the researcher.

**Ethical considerations**

Participation in this research was voluntary, with no incentive or remuneration offered to respondents. Although consent to use the data collected was stated to be implicit upon submission of a survey, this was further clarified by the inclusion in both surveys of a final question that enabled participants to ‘opt out’ once they had answered the survey if they chose to do so.

In line with universal research ethics recommendations (Creswell, 2013; Shaw & Barrett, 2006), issues of potential risk to stake-holders (participants, employing organisations and the researcher) were considered prior to commencing this project. The RNs involved in this
research have all experienced the emotional trauma of personal bereavement and therefore could be vulnerable. However, this potential risk to participants was mitigated by the choice of research methodology (a descriptive on-line survey rather than an interview approach) which allows nurses the time and space to answer the survey only if and when they feel they are able to do so without causing undue personal emotional harm. As discussed, RNs bereaved more recently than 18 months were excluded from participation in the research, as this cohort of nurses have an increased vulnerability due to the potential for complicated grief issues. Assurance was provided that any information inadvertently collected that indicated criminal behaviour or negligence on the part of any participant or their employing organisation, would not be published, or used in any oral presentation.

It is possible that the findings of this ‘mainstream’ research could have bearing for the tangata whenua (the indigenous people) of New Zealand due to the possibility of Māori nurse participation (Health Research Council of New Zealand, 2010). Respect was therefore paid to the concept of tapu (sacred) knowledge that inherently reflects Māori culture and the lessons learnt from those who have gone before. The elements of aroha (caring) and aro ki te ha (awareness) have been considered in the following ways:

- Participation. Māori nurses were invited to participate on a voluntary basis, in a similar fashion to nurses of other ethnic groups. Consent was considered to be implicit upon participation.
- Protection. A consultation process was entered into with the Māori Health Unit at the organisation in which the researcher was employed in order to ensure protection for Māori nurses.
- Partnership. It is believed that this research may help to address some of the inequalities in Māori mental health, by providing Māori nurses with a ‘voice’ regarding their particular needs following a personal bereavement. Additionally, current practice with regard to support of Māori nurses following a personal bereavement may be brought into clearer focus. Recommendations for further research based upon themes from the research will be made.

There is no increased personal or employment risk to the researcher in undertaking this study. On the contrary, this project provided a way of finding meaning out of a ‘senseless’ death and creating a positive outcome from a traumatic event. The researcher’s immediate manager and organisational leaders are fully supportive and encouraging of the study.
Data processing and analysis

The quantitative elements of this research have been analysed using standard methods – median, percentile, semi-quartile range and frequency distribution, with pie and bar charts used to display results. Fisher and Schneider (2007) confirm these methods as being statistically valid for nominal data (such as demographic information) and ordinal data (information ascertained via the use of Likert scales) where the intervals between rankings are inconsistent or cannot be measured. The use of Survey Monkey expedited this analysis process. The free-text qualitative portions of the questionnaires have been analysed by coding and categorizing, then grouped into themes and sub-themes as per Fisher and Schneider’s (2007) suggestion. Direct quotes from the research are used to support themes.

Chapter summary

In this chapter, the method utilised to undertake this research project is presented, with discussion regarding the choice and rationale of research framework and sampling methodology. The data collection tools used and the process undertaken to gain the required approvals and to disseminate the research links to potential participants is outlined. Reflection upon ethical considerations, with particular emphasis on ameliorating risk for participants, is provided. Data processing and analysis methods are discussed. The following chapter presents the research findings.
Chapter 4 Results

The experience of personal bereavement and the challenges faced when working in a staff nurse capacity immediately following my loss have been the principal motivators of this study. I noted a significant disruption to my core nursing values, and began to question my safety to practise independently upon first returning to work. Conversations with numerous nurses provided anecdotal evidence that this disruption to core nursing values may be a common experience for those who have suffered a personal bereavement and not one that was unique to me. The aims of this study have therefore been two-fold:

1. To establish the extent of existing policy and practice regarding bereavement support for registered nurses (RNs) working in the role of staff nurse, in secondary and tertiary healthcare services in New Zealand.
2. To ascertain the experience of RNs in the same practice settings, returning to work following a personal bereavement.

Thus two data sets have been generated, one from NMs and one from bereaved RNs working in staff nurse roles. In this chapter, data obtained from both surveys will be presented in written and graphical form. Based upon these results, themes worthy of further exploration in the following analysis chapter will be highlighted. Consistency and discrepancy between the two data sets will be noted.

Nurse manager survey

A non-probability purposive sampling method was employed for this NM study, with three DHBs non-randomly identified as being a representative sample of DHBs nationally. Approval was sought and gained from the ethics committees of these DHBs, and the dissemination of the survey link via senior nursing management at each DHB, saw 39 responses being received. Five of these were incomplete, containing demographic data only and were therefore deleted from the response pool. Inclusion criteria for this study dictated only team leaders or managers responsible for RNs working in staff nurse roles in secondary or tertiary care services in New Zealand were eligible to participate. Therefore three responses were disregarded from managers of primary health teams, or from those managing nurses working in senior nursing practice roles. Thus a total of 31 responses have informed this study.
As advised by nurse leaders from each of the participating DHBs, a total of 130 NMIs formed the potential population of this survey. The 31 responses received therefore represent a response rate of approximately 24%. Whilst this could be considered a low response rate, when combined with the descriptive text, a richer data set can be analysed (LoBiondo-Wood & Haber, 2010). Irrespective of the response rate, given that this is a novel topic of research and is previously unstudied, any information is therefore useful for laying a foundation for suggested future research.

Demographic data
Respondents were initially asked a series of questions about their personal details and work environments. The intent of these questions was to reveal useful quantifiable data regarding the respondent population pool and to serve as a cross-check of respondents’ work environments to ensure they complied with the inclusion/exclusion criteria of the study. As mentioned above, based upon information provided in the demographic questions, three responses were disregarded.

Question 1 – Gender
Two of the 31 respondents declined to provide their gender. Of the 29 who answered, 90% (n=26) are female and 10% (n=3) are male.

Question 2 – Nurse manager age

![Pie chart showing age distribution]

Figure 1. (NM Question 2) Nurse manager age.
Demographic information regarding age was also requested. All NMs who responded to the study provided this information, with the majority being in the 50-59 age category (55%). It is interesting to note that no responses were received from NMs aged less than 30 years or more than 60 years. Thus a narrower age distribution is seen in this NM survey than in the RN respondent pool. This will be discussed further in the following analysis chapter.

Question 3 – Nurse manager years of nursing experience

In question three, respondents were asked to specify their years of nursing experience, with all 31 participants responding to this question. One respondent indicates she has zero to four years of nursing experience. An explanatory comment to question seven explains that this respondent is an occupational therapist who has managed a team of nurses for a significant number of years, although she herself has no nursing experience. Inclusion criteria for this study include NMs who have direct team leader responsibility for RNs working in staff nurse roles in secondary and tertiary care services. This participant therefore is considered, for the purposes of this study, to be a NM, and her responses have been included in the study results.

All other respondents have greater than 10 years nursing experience, with over 70% (n=30) having greater than 20 years. The median years of nursing experience is 20-29 years.
Nurse managers were also asked to specify their years of nursing management/leadership experience. All respondents answered this question, with none having less than two years leadership practice and 81% (n=25) having over five years (median 5-9 years).

**Question 5 – Nurse manager area of clinical practice**
Participants were additionally requested to identify the clinical department they manage. One participant declined to provide this information, however, the remaining 30 responses represent a spread of clinical departments with surgical being the most common response, followed by medical, emergency and trauma, mental health and ‘other’ (‘other’ being identified as clinical bureau, pain management and outpatients). No responses were received from NMs of district nursing or palliative care.
**Question 5 – Area of clinical practice**

What type of clinical area do you currently have managerial responsibility for?

- Assessment and Rehabilitation/Elder Health
- Child Health (including Neonatology)
- District Nursing
- Emergency and Trauma
- Intensive Care/Cardiac Care
- Medical
- Mental Health
- Obstetrics/Maternity
- Oncology
- Perioperative Care
- Palliative Care
- Surgical
- Other (please specify)

**Figure 4. (NM Question 5) Nurse manager area of clinical practice.**

**Question 6 – Years in current management position**

How many years have you been in your current position?

- 0-1 year: 16.6%
- 2-4 years: 10.0%
- 5-9 years: 6.7%
- 10-15 years: 10.0%
- 16 years or more: 13.3%
- 3.3%
- 6.7%
- 10.0%
- 10.0%
- 6.7%
- 13.3%

**Figure 5. (NM Question 6) Years in current management position.**

34
Also of interest, is the tenure of each NM in their present nursing leadership position. All respondents replied to this question, with the majority having been in their current roles between two and nine years (71%, n=22). The median tenure in the current management position is 5-9 years.

**Question 7 – Registered nurse responsibilities**

In question seven, participants were asked to stipulate the number of RNs working in staff nurse roles for whom managerial responsibility is assumed. All 31 study participants responded to this question, with managerial responsibility ranging from three RNs to over 100. The total number of RNs identified in this question is calculated to be over 970, with each NM therefore being responsible for an average of 31 RNs.

**Question 8 – Number of registered nurse bereavements in the past year**

In order to establish the frequency with which NMs are faced with supporting a RN on their team experiencing a personal bereavement, data were requested regarding the number of RNs experiencing a personal bereavement in the past year. All survey participants provided this information. Interestingly, the experience of personal bereavement is virtually universal to all teams, with only one NM (responsible for 15 RNs) indicating no RNs on her team experienced a personal bereavement in the previous 12 months. Unfortunately, some managers were not specific in their responses, simply indicating ‘several’ or ‘uncertain’. One manager indicated that 90% of the 80 RNs she was responsible for managing had experienced a personal bereavement. Supporting comments from this NM do not indicate whether this is indeed her experience (for example, resulting from the death of a team member) or a misinterpretation of the question and this participant’s response has therefore not been included in the analysis of this question. When the unspecific responses (such as ‘uncertain’ and ‘several’) were also disregarded a response pool for this question of 28 remains. Of these 28 responses, the number of bereavements identified totalled 143, which represents 18.6% (a little under one-fifth) of the total number of RNs managed by these same 28 NMs (as per information gathered in question seven). This will be highlighted as a theme and discussed in the following chapter.

**Bereavement policy within District Health Boards**

In order to determine the extent and content of existing organisational policy with regard to bereavement leave and bereavement support within the participating DHBs, two questions were asked.
Managers were asked if their organisation has policies to support RNs to work following a personal bereavement. Seventy percent \((n=21)\) of the 30 respondents who answered this question indicated the presence of written policy to assist in supporting bereaved RNs. Seven percent \((n=2)\) answered ‘no’ to this question. Interestingly, 23% \((n=7)\) of managers did not know if their DHB offers written policy to assist in managing bereaved nurses, despite the vast combined experience of the NM cohort as seen in question six and the almost universal manager experience of RN personal bereavement described in question eight. This lack of leadership understanding regarding organisational policy will be discussed further in the analysis chapter.

**Question 10 – Content of written policy**

This question provided a series of statements for which participants were able to respond to all points provided. The question asked those who responded positively to question nine, to identify the content of their bereavement policy. The points were:

- Provides guidance regarding accessing paid bereavement leave
- Provides guidance regarding amount of paid bereavement leave
- Provides guidance regarding accessing unpaid bereavement leave
- Provides guidance regarding amount of unpaid bereavement leave
- Provides guidance regarding how to talk with the bereaved RN
- Provides practical suggestions of how to support the bereaved RN
- Provides guidance regarding how to support other team members/colleagues of the bereaved RN
- Provides guidance regarding accessing professional counselling for the bereaved RN
- Provides a list of resources available to support the bereaved RN
- I don't know the content of this policy
- Other (please specify)

![Pie chart showing the content of the policy](image)

Figure 7. (NM Question 10) Content of written policy.
It is interesting to note that 10 respondents did not answer this question, meaning that those who responded to question nine with ‘did not know’ \((n=7)\) also did not consider this question. All 21 managers who answered ‘yes’ to question nine provided responses to this question, with over 90% \((n=19)\) indicating that their written policy provides guidance regarding accessing and the duration of paid bereavement leave. Fifty-seven percent \((n=12)\) and 48% \((n=10)\) indicate that policy also assists them with accessing and the duration of unpaid bereavement leave respectively. Assistance with accessing professional counselling for the bereaved RN also features 48% \((n=10)\) of the time. One NM, who indicates the presence of bereavement policy within their DHB, did not know the content of this policy, and a different NM notes that “other HR [human resources] policies and guidelines may also be applicable” (NM#11).

The experience of supporting registered nurses who have had a personal bereavement

The following questions were intended to elicit detail regarding strategies taken by NMs to support bereaved RNs both during the bereavement leave period and upon return to work.

Question 11 – Involvement with registered nurses taking bereavement leave

In the past five years, in your role as team leader, have you been involved with a registered nurse working in a staff nurse role, taking bereavement leave?

![Figure 8](image.png)

In this question, NMs were asked if they had been involved with a RN in their team taking bereavement leave. Thirty of the 31 participating managers replied to question 11, with 26 (87%) of them responding in the affirmative.
Question 12 – Options made available to registered nurses

In this question, respondents who answered in the affirmative to question 11 were invited to indicate support options made available to RNs taking bereavement leave. Of these 26 managers, 77% (n=20) indicate they offer the RN flexibility with regard to the length of approved paid leave, and 50% (n=13) provide flexibility with regard to the length of approved unpaid leave. Eight respondents ticked ‘other’ with comments supporting the recognition of a need for additional leave beyond paid bereavement leave. The majority indicate they offer a variety of counselling support and a mix of annual leave, bereavement leave or special leave with the organisation assisting with payment of these supports, for example:

“Since work force includes more migrant nurses, annual leave with bereavement leave is given to support staff during their bereavement period” (NM#16)

“Access to counselling through EAP [Employee Assistance Programme]/ Occ. Health [occupational health]” (NM#7)

One respondent notes, “I work alongside the staff member to ensure their wellness” (NM#3).

Question 13 – Assessment of registered nurses safety to work

This question invited respondents to indicate whether or not the bereaved RN was assessed as being safe to work prior to return to work. Twenty eight NM responded to this question, with
less than 18% \((n=5)\) indicating that prior to returning to work, the RN was assessed as being safe to practise. This will be explored further in the analysis chapter, as a significant theme.

![Pie chart showing prior to returning to work, was the registered nurse assessed as being safe to work?](image)

Figure 10. (NM Question 13) Assessment of registered nurses safety to work.

**Question 14 – Factors considered as part of an assessment of registered nurses safety to work**

Those managers, who answered in the affirmative to question 13 with regard to RN assessment of safety to work, were asked to comment upon factors considered in this assessment. Those who indicated in question 13 that they did not undertake an assessment were also invited to comment upon factors influencing this practice. Eleven managers provided comments. Responses suggest that this aspect of bereavement support is not fully considered, describing the use of informal assessment, for example:

“No formal assessment, checked in regularly with RN prior to return to work” (NM#26)

“Have a chat” (NM#16)

Other managers state the RN self-assessed their safety to return to work:

“Went by the individual nurse’s views of themselves” (NM#7)

“The nurses themselves decided to come back to work, and appeared fit” (NM#6)

One manager notes that the nurse’s particular circumstances were taken into account when assessing his/her safety in returning to work:
“Discussion with the RN. Factors influencing the discussion and decision included whether sudden death, relationship to person who died, in one case the number of recent bereavements in the family ... distance travelled to funeral, family dynamics” (NM#1)

One manager responds, “Not sure. Never knew we needed to assess this” (NM#12)

**Question 15 – Support of registered nurses returning to work following a personal bereavement**

In the past five years, in your role as team leader, have you been involved with supporting a registered nurse returning to work following a personal bereavement experience?

- Yes: 70.0%
- No: 30.0%

![Figure 11. (NM Question 15) Support of registered nurses returning to work following a personal bereavement.](image)

Managers were asked to indicate their involvement with supporting a RN returning to work following a personal bereavement. Of the 30 NMs responding to this question, 21 (70%) experienced this in the past five years.

**Question 16 – Options made available to the registered nurse returning to work**

Nurse managers who responded positively to question 15 were invited to share what options they made available to support bereaved RNs upon returning to work. All 21 managers who responded to question 15 replied to question 16. Seventy six percent (n=16) of them indicate that they offer flexibility with regard to work hours, and 38% (n=8) offer flexibility with regard to work load, for returning bereaved RNs. Forty-three percent (n=9) of managers responded to the ‘other’ option, with comments indicating the offer of additional leave and the involvement of the wider team in the RNs return to work:

“Karakia [prayers] and mihimihi [greetings] on return to work” (NM#15)
“Ensure that with the RN’s permission her colleagues are aware of her situation and are able to support” (NM#16)

Some managers indicate that informal conversations are support options offered:

“Have meetings on days off and sharing lunch, talking and listening” (NM#31)

“Asking them what they needed” (NM#17)

Figure 12. (NM Question 16) Options made available to the registered nurse returning to work.

Question 17 – Culturally appropriate support

I offer support to registered nurses who have experienced a personal bereavement in a way that is culturally appropriate to the bereaved nurse

Figure 13. (NM Question 17) Culturally appropriate support.
This question asked respondents to say whether the support offered to nurses was culturally appropriate. Twenty seven managers replied with all either strongly agreeing or agreeing that they provide culturally appropriate support to bereaved RNs:

“Flexibility [is provided] in terms of travel overseas or allowing time to participate in a memorial service if unable to travel” (NM#7)

One manager indicates that her desire to provide culturally appropriate support clashes at times with the needs of the department:

“We do this the best we can but there are times when service need must take priority” (NM#11)

**Question 18 – Advice regarding professional counselling and support**

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Figure 14. (NM Question 18) Advice regarding professional counselling and support.

Respondents were asked if they provide advice to the RN about professional counselling and support available to them. Of the 27 managers who replied to this question, 24 indicated either strong agreement or agreement with the statement ‘I always advise the bereaved RN about the professional counselling/support available to him/her’. Eleven percent (n=3) indicated disagreement with this statement.

**Nurse managers’ perceptions of their bereavement support.**

The remaining questions focussed on NMs perceptions of their own practice with regard to bereavement support for RNs in their team. Information regarding organisational bereavement training and resources available for use was also sought.
Question 19 – Confidence in managing bereaved registered nurses

In this question, respondents were asked if they felt confident in providing support to registered nurses who have experienced a personal bereavement. The majority of the 26 managers who responded to this question feel either confident (n=14) or strongly confident (n=9) in providing support to bereaved RNs. Only three managers (12%) indicate that they do not feel confident in this matter.

Question 20 – Management of bereaved nurses

Figure 16. (NM Question 20) Management of bereaved nurses.
Respondents were then asked to rate themselves on how well they think they manage bereavement. Of the 27 managers responding to this question, 24 (89%) feel they manage the support of bereaved RNs well, three do not.

**Question 21 – Professional counselling and support**

![Figure 17. (NM Question 21) Professional counselling and support.](image)

In this question, NMs were asked to identify the types of professional counselling or crisis intervention support offered to bereaved RNs. Two managers declined to answer this question. All of the 29 who replied, indicate that an EAP is offered to bereaved RNs in their organisations. Additionally, 55% (n=16) offer the services of the hospital chaplain and 38% (n=11) offer professional supervision. Three managers offered the services of the DHB’s occupational health team, and two mention peer support. One manager comments:

“Other [supports] are available, but I have never thought to offer – I will in the future”
(NM#17)

**Question 22 – Written resources regarding bereavement**

Managers were then asked to indicate the availability of written bereavement resources within their organisations. Of the 29 NMs who answered this question, 10 (34%) indicate that written resources regarding bereavement and grieving are available, whilst 19 (66%) feel that such resources are not available.
Information regarding NM education was felt to be an important aspect of this study and respondents were therefore asked if they felt they had received enough training and professional development with regard to bereavement support. Thirty of the 31 participating managers responded to this question, with 47% (n=14) indicating they feel they have received enough training, education or professional development to help them support bereaved RNs. Conversely, 53% (n=16) of managers feel they have not received sufficient training with regard to this topic.
“I have not received or been offered this type of training” (NM#6)

“We could do a lot better” (NM#3)

Given that over half of the NMs participating in this study feel they have not received sufficient professional development with regard to bereavement support, this theme will be discussed further in the following chapter.

*Question 24 – Other comments*

Nurse managers were then given the opportunity to add further comments regarding any aspect of the bereavement care they provide, or would like to provide. These comments have been used to inform the ensuing analysis and discussion chapter.

*Question 25 – Consent*

One NM exited the survey site prior to answering this question. All other participants consented to data being submitted.

**Summary of findings from nurse manager survey**

Thirty one responses to this NM survey have been presented in this chapter. Although the responding cohort is relatively modest in size, the information provided by these NMs provides interesting and insightful reading, given the dearth of previous studies on the topic. The respondents represent a wide distribution of clinical departments and are an experienced nursing management workforce. The cohort has a median of 20-29 years of nursing experience and a median of five to nine years of nursing management practice. More than 90% of these nurse leaders have been in their current roles more than two years. The experience of supporting a bereaved RN is almost universal to all NMs, with only one manager not having to face this issue in the past year. This nursing leadership group identifies that nearly one-fifth (18.6%) of the RNs they manage experienced a personal bereavement in the previous 12 months.

Seventy percent of NMs acknowledge the presence of organisational policy which largely relates to the provision and amount of paid and unpaid bereavement leave, and guidance to accessing professional support services. Interestingly, 23% of respondents do not know if their organisation has bereavement policy, despite their universal experience of recent RN bereavement, and their extensive years of nursing management practice.
Common supports offered to bereaved RNs immediately following the bereavement, include flexibility with regard to length of paid and unpaid bereavement leave. A number of managers recognise the need for additional leave beyond paid statutory entitlements and a willingness to explore a variety of leave options. The services of occupational health, counselling support and professional supervision are strategies used by managers to support bereaved RNs.

Of concern, is the finding that less than 18% (only five of 28) NMs undertake an assessment of the bereaved RNs safety to work prior to the recommencement of nursing duties. Comments indicate that this aspect of bereavement support is not fully considered, with the few assessments that are undertaken, frequently being informal or casual, or the bereaved RN is asked to self-assess their own safety.

Upon recommencement of nursing duties, 76% and 38% of NMs indicate that they offer bereaved RNs flexibility with regard to work hours and work load respectively. All NMs state that they offer culturally appropriate bereavement support, however some recognise that at times there is conflict between this and the needs of the service they manage. Similarly, nearly 90% of leaders state that they always advise the bereaved RN of the professional counselling and support services available, including EAP, hospital chaplain service, professional supervision, and occupational health. Only 35% of managers indicate the availability within their organisation of written bereavement resources.

The large majority of NMs indicate they feel confident with providing support to bereaved RNs and believe they manage the support of these nurses well. This is despite more than half of them stating they have received insufficient professional development to help them in this.

**Registered nurse survey**

As with the NM study, a non-probability purposive sampling method was employed, with three DHBs non-randomly identified as being a representative sample of DHBs nationally. Approval was gained from these three DHBs to allow RNs in their employment to participate. However, unlike the NM study, in order to increase sample size and decrease study limitations, survey links for the RN survey were also disseminated via the Facebook pages of the New Zealand Nurses Organisation (NZNO) and the academic institution supporting this research. Furthermore, the strategy of snowballing was utilised, with RNs being invited to forward survey information and links to others in their employment and social networks, whom they
felt may be interested in participating. For this reason, the potential population of this RN survey is unknown and a response rate cannot be calculated.

A total of 112 responses were received to this survey, 110 directly via Survey Monkey, and two in written format, delivered anonymously to the researcher at her place of employment. These two responses were then loaded by the researcher onto the Survey Monkey database. Four responses were deleted as they solely contained demographic data, with only questions one to six being answered. The Research Ethics Approval for this study dictated that participants be working in the role of staff nurse, within secondary or tertiary care services in New Zealand at the time of their bereavement. Additionally they must have experienced a personal bereavement more than 18 months, but less than five years ago. It was felt that the safety of those who had been bereaved less than 18 months previously could not be ensured and that information provided by nurses bereaved greater than five years ago, would not inform current practice. Thus eight responses were deleted as the participants were either working in an area other than secondary or tertiary care services or in a position other than staff nurse (or equivalent). Additionally, 30 responses were filtered from the final data analysis as they were completed by nurses who had experienced their bereavement less than 18 months or more than five years previously. Thus a total of 70 responses met the study inclusion and exclusion criteria and are presented here.

**Demographic data**

As with the NM survey, a series of demographic questions were first asked to verify personal and employment characteristics of the participant cohort. This information also served as a useful cross-check to ensure only responses from nurses working in the role of staff nurse in secondary or tertiary care services in New Zealand were analysed. As outlined above, eight responses were disregarded on this basis.

**Question 1 – Gender**

Of the 68 respondents who answered this question, 94% (n=64) are female, and 6% (n=4) male.

**Question 2 – Registered nurse age**

Responding nurses were asked to identify what age group they were in at the time of participating in the research. Sixty nine respondents answered this question, with the majority of respondents (83%, n=57) being over 40 years old. The median age was 40-49 years old.
Question 3 – Ethnicity

Given that the response to bereavement is a culturally dependent phenomenon (Oyebode & Owens, 2013), participants were asked to identify the race or ethnicity they most closely identify with. All respondents answered this question, with the majority (71%, n=50) identifying as Pākehā (New Zealand European). Thirteen percent (n=9) identify as ‘other’ European and 9% (n=6) as Pacifica. Only three New Zealand Māori nurses (4%), one nurse of Asian descent and one of African descent responded to the survey.
Question 4 – Registered nurse years of nursing experience

In question four, nurses were asked to specify their years of nursing experience. Once again, all respondents answered this question, and the results indicate that these nurses are very experienced with 59% (n=41) of respondents having over 20 years of nursing experience, and an additional 23% (n=16) having between 10 and 19 years of nursing experience. The median number of years of nursing experience was 20-29 years (which interestingly is the same result as seen with the NM cohort). The majority of these nurses are therefore very familiar with the profession of nursing and are unlikely to be naïve to life and death issues. Further discussion on this topic will ensue in the following chapter.

Question 5 – Registered nurse area of clinical work

The intent of question five was to elicit information regarding nurses’ area of clinical practice. These responses are useful in verifying that participants were working in secondary or tertiary care services (as per the inclusion criteria of the study), as well as contributing to the overall picture of the responding RN cohort. A wide distribution of clinical departments can be seen by the 70 respondents who answered this question. Surgical (19%, n=13) and intensive care/cardiac care (17%, n=12) are the most represented areas, followed by medical (n=10), mental health (n=8), with five nurses each from child health, emergency and trauma, oncology, and ‘other’ departments. Those who identify as ‘other’ stated they were working in outpatients, cardiac rehabilitation, haematology, gastroenterology, and nursing research. Nearly one-quarter (n=17) of the 70 respondents were working in a critical care department (that is, either intensive care/cardiac care or emergency and trauma) at the time of their loss.
No responses were obtained from nurses working in palliative care, however, this is unsurprising as palliative services are generally delivered in New Zealand by primary health providers and these nurses would therefore not meet the inclusion criteria of this study.

Figure 23. (RN Question 5) Registered nurse area of clinical work.

**Question 6 – Length of time in department at time of bereavement**

The final demographic question related to identifying the length of time that nurses had been working in their area of clinical work at the time of their bereavement. All respondents answered this question, with only six nurses (9%) having worked in their departments for less than two years. Thus the majority of nurses (91%) were settled within the department for longer than two years and were therefore likely to be familiar with their departments, workloads, routines, colleagues and managers (and vice versa).
Bereavement demographics
A series of questions were asked in order to gain a picture of those who died, the circumstances of their death and their relationship to the nurse surveyed.

Question 7 – Length of time since bereavement

The first question in this series asked nurses to indicate how many years it had been since their loved one died. This question provided information that served to consolidate the survey population pool, as nurses were asked to indicate if their bereavement was less than 18 months, more than 18 months but less than two years, more than two years but less than three years, more than three years but less than four years, more than four years but less than five years, or more than five years.
months or more than five years previously. The research ethics exclusion criteria of the study, dictated that these nurses’ responses (n=30) be excluded from the study, as it was felt that the safety of those who had been bereaved in the previous 18 months (n=21) could not be ensured. Those who had been bereaved more than five years ago (n=9) were also excluded, as information provided by these nurses would not inform current practice. That said, and despite these responses being disregarded, the researcher believes this forum has provided a beneficial outlet for these nurses to express their feelings and experience of loss.

All 70 nurses who meet the study criteria responded to question seven, with a relatively even distribution of years since bereavement being seen (with the exception of only six percent of respondents having been bereaved between three and four years ago).

**Question 8 – Age of the loved one who died**

![Pie chart showing age of loved one who died]

In question eight, respondents were asked to indicate how old their loved one was when she/he died. All 70 respondents answered this question, with the vast majority of nurses indicating that their loved one was either over 70 years old (51%, n=36), or 45-69 years old (34%, n=24). The median age at time of death was between 45 and 69 years old.

**Question 9 – Relationship to the loved one who died**

In order to clarify the types of relationships affected by the death, nurses were asked to identify who had died, be it a first degree family member, an extended family member, friend, colleague or ‘other’. All 70 respondents replied to this question, with the death of a parent
being the most common experience (46%, \(n=32\)), followed by an extended family member (14%, \(n=10\)), ‘other’ (11%, \(n=8\), predominantly the deaths of in-laws) and siblings (10%, \(n=7\)). This dominant phenomenon of parental death will be discussed further in the next chapter.

![Figure 27](image.png)

**Figure 27. (RN Question 9) Relationship to the loved one who died.**

**Question 10 – Cause of death**

![Figure 28](image.png)

**Figure 28. (RN Question 10) Cause of death.**
It was anticipated that nurses experiencing the loss of a loved one due to unexpected or traumatic causes, may have different needs to those who had anticipated their loss for some time, therefore information was gathered in question 10 to inform this. There was a 100% response rate to this question, with 56% (n=39) of respondents indicating that the death of their loved one was unexpected and 36% (n=25) were as a result of natural causes. It is interesting to note that one-fifth (n=14) of the respondents’ loved ones died traumatically, that is, unexpectedly as a result of accident or injury, violence or suicide.

*Question 11 – Nature of the relationship with the loved one who died*

![Figure 29. (RN Question 11) Nature of the relationship with the loved one who died.](image)

Nurses were asked to also provide information describing their relationship with their loved one who died. All nurses responded to this question, with the overwhelming majority describing their relationship with the one who died as being either extremely close (44%, n=31) or close (43%, n=30).

**Support received from the nurse manager immediately following bereavement**

A series of questions were then asked of respondents, to elucidate bereaved RNs’ experiences immediately following their bereavement and before returning to work.

*Question 12 – Communication with manager*

In question 12, participants were asked the extent to which they agreed or disagreed with the statement ‘following my bereavement but before my return to work, my manager communicated well with me’. Sixty-six of the 70 nurses responded to this question.
Figure 30. (RN Question 12) Communication with manager.

Fifty-three percent \( (n=35) \) of respondents indicate that their manager communicated well with them in the time frame following their bereavement but prior to returning to work. Comments made to support this include:

“[My manager] contacted me immediately following death. Communicated with me during the time off work” (RN#26)

“I was on annual leave at the time of death and rang to change the rest of my leave to bereavement leave. My charge nurse was very understanding and asked me to let her know if there was anything they could do and once arrangements were made for the funeral to let them know of the details” (RN#35)

However, 47\% \( (n=31) \) of respondents indicated that their manager did not communicate well with them during this time, with many responses indicating there was little or no communication with the nurse immediately following the bereavement:

“I heard nothing at all from them” (RN#2)

“My manager did not contact me while I was away” (RN#9)

In some cases, all communication was via a third party:

“It was the PA [personal assistant] that communicated” (RN#40)
“I communicated more with my unit colleagues, rather than with my manager re returning to work” (RN#59)

When the data are analysed according to ethnicity, Pākehā (New Zealand European) verses non- Pākehā, the results remain unchanged indicating that ethnic background is not a significant moderating factor with regard to the quality of the manager’s communication, or the perception of same by the RN. This theme of communication in the days immediately post bereavement, will be further explored in the discussion chapter following.

Question 13 – Managers understanding of nurses’ particular needs

It was anticipated that results from both the demographic questions and from those relating to the bereavement itself, would evidence variability in nurses’ cultural heritage, age, stage of professional career, and circumstances of bereavement. It was therefore important to expose the RNs perceptions of the extent to which their unique needs were understood by their manager. Sixty-six nurses replied to this question, with 53% (n=35) indicating that their manager did understand their particular needs to support themselves and their family during this time. However, 47% (n=31) of nurses feel that their manager did not understand their individual needs:

“I am left feeling that my circumstances and family do not mean anything despite the fact that we had worked together in the same service for years” (RN#58)
One Pacifica nurse stated, “I am still not sure how much she knows about my culture and process for grieving” (RN#32)

Despite this comment, there is no overall difference in the data between the experiences of Pākehā (New Zealand European) and nurses from other cultures, with regard to the nurses’ perceptions of the manager’s understanding of their individual needs. This finding that nearly half of respondents do not feel that their individual needs were identified and understood, will also be discussed in the ensuing chapter.

Question 14 – Respect

![Bar chart showing responses to Question 14: Respect](image)

In question 14, respondents were asked to indicate the extent to which they feel their manager had treated them with respect. Seven of the 70 nurses declined to answer this question. Of the remaining 63 nurses, 75% (n=47) signify that they were treated with respect by their manager:

“She understood my need to grieve” (RN#60)

“[She] was very understanding, did not question detail and offered additional time if required” (RN#27)

When the data are analysed from a cultural perspective, 46 of the respondents to this question are of Pākehā (New Zealand European) heritage and 78% (n=36) of them feel they were treated with respect. This is in contrast to the 17 nurses of other cultures, of whom only 65% (n=11) perceive they were shown respect by their manager. Thus a little less than one-quarter
of Pākehā (New Zealand European) nurses, and over one-third of nurses of other cultures, feel they were not treated with respect:

“[A] ‘life goes on’ approach was adopted after the official three days of bereavement leave” (RN#57)

“The comment of ‘I’m sorry to hear of your loss’ on my return to work, is the only support/communication I received from my manager. I felt it was flippant and said only because ... that’s what you say!” (RN#69)

**Question 15 – Compassion**

![Bar chart showing the responses to the question: My manager was compassionate towards me.]

In a similar vein to the preceding question, nurses were asked about their perceptions of how compassionately they were treated by their manager. Of the 64 respondents to this question, 64% (n=41) either strongly agree or agree with the statement ‘my manager was compassionate towards me’, with supporting comments such as:

“I had several meetings with my manager where she appeared to understand and empathise with my feelings” (RN#60)

“[She] asked if I needed to take any extra leave and that it could be sorted out if required. [She] asked my permission to let the rest of my colleagues know about my Dad’s passing and if they could attend the service. They sent flowers and a card which was touching” (RN#35)
However, 36% (n=23) of respondents either disagree or strongly disagree with the statement, indicating a perceived lack of compassion. One Pacifica nurse who unexpectedly lost her mother in the Islands states:

“I asked for annual leave so I can go to the Islands. [She] took ages to give me an answer, more than 48 hours” (RN#61)

Another nurse whose parent died, and to whom she was extremely close states:

“They never mentioned the death at all” (RN#2)

A difference is noted when data are analysed by cultural heritage. Of the 47 Pākehā (New Zealand European) nurses who responded to this question, 66% (n=31) of them feel they were treated with compassion, whilst only 59% (n=10) of the 17 respondents from non- Pākehā (non-New Zealand European) cultures agree. Discussion of these cultural differences will form part of the analysis chapter.

**Question 16 – Leave entitlements**

![Bar chart](chart.png)

Figure 34. (RN Question 16) Leave entitlements.

Nurses were then asked to indicate the extent to which their managers had assisted them to work out their leave entitlements. Of the 64 nurses responding to this question 53% (n=34) feel their manager did assist them to work out their leave entitlements, whilst 46% (n=30) disagree. No difference is noted between the experience of Pākehā (New Zealand European)
nurses and those of other cultures. This variability in results with regard to assistance to access leave will also be discussed in the following chapter.

**Question 17 – Professional support services**

This question relates to assistance to access professional support services. Sixty-six nurses responded to this question, of which only 47% \( n=31 \) indicate that their organisation offered assistance with accessing professional support services if required.

![Figure 35. (RN Question 17) Professional support services.](image)

Interestingly, each of the participating organisations employs an external professional counselling service, which is available to staff members, such as an EAP. However, during their bereavement time, many nurses remained unaware of the services available to them:

“[I] wasn’t offered any help or counselling. I later learned that our hospital has an employee assistance programme that I could have attended, but I didn’t know about it at the time” (RN#21)

The value of EAP is questioned by some nurses:

“EAP is something that sits in the background but is never discussed openly, most staff joke that you just go and have a cup of tea with someone at EAP, and what is the use when you then have to pay for it yourself after three sessions, which may only touch the tip of the iceberg” (RN#1)

“I declined as I find EAP not useful” (RN#31)
One nurse, who worked in intensive care and was encouraged to talk with the department psychologist, says that if she had wanted other professional support, she would have had to ask for it. Similarly, another nurse implies the absence of any offer of professional support was due to her own inaction:

“Maybe its [sic] because I did not ask” (RN#14)

Given each of the participating DHBs employs a professional counselling service for staff members and their families, further discourse regarding the limited access to and use of professional support for bereaved nurses, will occur in the ensuing chapter.

Question 18 – Written bereavement resources

![Bar chart showing responses to Question 18](image)

In this question, nurses were asked if they were offered written resources about bereavement and grieving, that could help them understand what they were experiencing. Five of the total cohort of 70 nurses declined to answer this question. Of the remaining 65 nurses, an overwhelming 95% (n=62) feel they were not offered any such resources. Three nurses comment that they would not have wanted such resources at the time.

Nurses’ return to work experiences following bereavement

The following seven questions explored the bereaved nurses’ return to work experiences, including assessment of safety to work, manager support and strategies used to ease the transition back to practice.
Question 19 – Bereavement policy

In the first of these seven questions, respondents were asked if their organisation had written policy regarding employees working following a personal bereavement. Sixty-four of the 70 nurses replied to this question with 75% (n=48) stating that they ‘did not know’. Nine nurses (14%) indicate such policy is available within their workplaces, whilst seven nurses (11%) believe this is not the case.

Question 20 – Assessment of the nurse’s safety to work

Prior to returning to work, my manager and I discussed whether or not I was safe to recommence working

Figure 38. (RN Question 20) Assessment of the nurse’s safety to work.
Information was sought in this question, to determine the extent to which the RNs safety to work was discussed prior to the recommencement of duties. The same 64 nurses who responded to the previous question also answered this question. Interestingly, 83% ($n=53$) either feel or strongly feel that there was no discussion entered into with their manager regarding their safety to work following their bereavement:

“Services were stretched, so it was ‘business as usual’ including overtime and double shifts at times” (RN#49)

“There was no discussion about whether I was safe to recommence work. It was expected that I was to return to work the day after my grandfather’s funeral, I ended up calling in sick the following day as I felt I was not safe to work” (RN#11)

This topic of assessment of safety to work, as mentioned in the summary of the CN survey, will be a key feature of the discussion chapter.

**Question 21 – Managerial support upon return to work**

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Figure 39. (RN Question 21) Managerial support upon return to work.

Once again, the same 64 nurses answered this question in which respondents were requested to indicate the degree to which they felt supported by their manager upon return to work. The majority ($n=41$, 64%) describe their manager as being supportive of them upon recommencement of nursing duties:

“She asked me if I was OK and how myself [sic] and the family were coping. [She] tried to give me a fair roster and workload in the first couple of weeks” (RN#35)
However, 36% \((n=23)\) of nurses indicate that they had felt unsupported by their managers when returning to work:

“Everyone was aware my Dad had died and how extremely close I was to him, but I was certainly not asked by my co-ordinator or managed how I was doing” (RN#69)

“I felt I had inconvenienced the service! Comments from my manager left me with these thoughts e.g. ‘the team have had to really pull it together whilst you’ve been gone’” (RN#58)

“After her initial hello and how are you [sic], it was like she was avoiding me. I felt that she didn’t really want to know how I was doing, because then she might have to do something to help me and she didn’t want that extra hassle in her already busy schedule” (RN#21)

This perceived lack of support will be another of the issues explored in the next chapter.

**Question 22 – Individual concerns of nurses**

![Bar chart](image)

In this question, further information was sought regarding the RNs perception of having their concerns about resuming work listened to and acknowledged by their manager. Five of the 70 respondent pool declined to answer this question. The majority of nurses (69%, \(n=45\)) feel that the concerns they had regarding returning to work were listened to and acknowledged by their manager however, 31% \((n=20)\) feel that they were not. Interestingly, when the data are...
reviewed with regard to ethnicity, these percentages alter. Of the 48 Pākehā (New Zealand European) nurses who responded to this question, 29% (n=14) feel that their concerns about returning to work were not acknowledged. This contrasts with 35% (n=6) of the 17 nurses from cultures other than Pākehā (New Zealand European), who felt similarly.

**Question 23 – Flexibility of work options**

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Figure 41. (RN Question 23) Flexibility of work options.

Nurses were then asked to indicate the degree to which they were offered flexibility of work options upon resumption of duties. Of the 65 nurses who responded to this question, 78% (n=51) feel that they were not offered flexible work options upon returning to work.

**Question 24 – Flexibility of workload**

Similarly, nurses were also asked to indicate the degree to which they were offered the possibility of a reduced workload in the early days of resuming work. Having the option of reduced patient numbers or reduced patient acuity upon return to work was not an option for the vast majority (88%, n=57) of the 65 nurses who provided information to inform this question.

The responses to both question 23 and 24 with regard to flexibility of work options and workload will be addressed further in the next chapter.
Question 25 – Collegial support

In this question, nurses were requested to note how supported they felt by their colleagues upon returning to work. A significant number (85%, n=55) of the 65 nurses who answered this question feel that colleagues had supported them well after returning to work. This is in contrast to the responses to question 21, when only 64% (n=41) of nurses feel that their NM had supported them well during the same period. Further discourse regarding the importance of support during this critical return to work period will be provided in the following chapter.
**Nurses’ feelings upon return to work**

The next six questions focussed on nurses’ feelings and grief symptoms upon resuming work.

**Question 26 – Safety to work**

The first question in this section asked nurses if they felt safe to work, upon resuming shifts. Of the 64 nurses who replied to this question, 28% ($n=18$) feel that they were unsafe when they returned to work:

- “I had difficulty concentrating, and found I got easily fatigued” (RN#49)
- “I was too emotionally distracted to function normally” (RN#36)
- “I would remove myself from the ward and sit in the toilet to get away from the noise and stress ... I felt pulled in different directions” (RN#30)
- “I was slow to react and didn’t read situations very well. I didn’t care much about anything or anyone” (RN#21)
- “I was not in the right head space to return to work but felt that I had no excuse to not return to work and was very negative about work for a while” (RN#18)

The remainder of nurses (72%, $n=46$) feel they were safe to work and some welcomed work as a positive distraction from their grieving:

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**Figure 44. (RN Question 26) Safety to work.**

The bar chart illustrates the nurses' responses to the question of feeling safe to work upon resuming shifts.
“When I put on that uniform, I am a total professional ... I know how to put aside family concerns and focus on the needs of the patient” (RN#57)

“I felt safe and my colleagues were very considerate and watched out for me” (RN#37)

“I felt that work was a place that felt safe and secure and supportive and I could escape from my grief at being in the house” (RN#26)

As indicated in the summary of the NM survey, this aspect of safety to work will be given considerable attention in the discussion chapter.

**Question 27 – Critical analysis skills**

![Bar chart](image)

To elicit further information regarding safety to work, nurses were asked to identify if they felt their critical analysis skills were intact upon resuming duties. Concerningly, 34% (n=22) of the 64 nurses who responded, describe a disruption to their critical analysis skills at that time. Comments made in further explanation, indicate some self-awareness of this issue:

“"I was aware that my judgments in certain areas were impacted” (RN#35)

“I felt blunted” (RN#60)

“I doubted myself a lot” (RN#18)

One nurse indicates that at the time she thought her critical analysis skills had been intact however, in hindsight, she felt differently:
“At the time I felt that I was OK, but looking back I think I was on auto pilot” (RN#17)

A number of respondents comment that they relied on collegial team dynamics to maintain client safety:

“I called the doctor and made it her problem because I couldn't think straight ... Once it was only a comment from one of the other nurses about my patient that made me realise my patient wasn’t doing so well. I hadn’t noticed” (RN#21)

“I discussed any decisions I was making with colleagues” (RN#37)

“I utilised the support of colleagues in critical analysis when feeling I was not functioning as well as normally” (RN#49)

This significant disruption to nurses’ critical analysis skills and the impact upon their safety to work will further inform discussion in the analysis chapter.

**Question 28 – Physical symptoms of grief**

![Physical symptoms of grief](image)

Figure 46. (RN Question 28) Physical symptoms of grief.

In the following four questions nurses were asked to identify different types of grief symptoms, noting as many or as few symptoms as they were experiencing upon returning to work. The results of all four questions will augment the discussion regarding safety to work outlined in the following chapter. The first of these questions, related to the experience of
physical grief symptoms. The most frequently experienced physical grief symptoms of the 61 respondents upon return to work, were fatigue (experienced by 64% of nurses, n=39), frequent tearful episodes (57%, n=35) and insomnia (48%, n=29). Listlessness, loss of appetite and headaches were also common. Those who responded to the ‘other’ category predominantly used this to provide comment in support of symptoms already identified. Some nurses searched for safe places in which they could express their grief:

“The district nurse’s car is a good place to have a howl!” (RN#55)

“Tearfulness in private” (RN#8)

Interestingly, two nurses attribute their fatigue to jet lag:

“Jet lag for first month” (RN#31)

“I put a lot of my symptoms down to jet lag, but now think that I just didn’t have time to grieve” (RN#17)

Some nurses found work to have therapeutic value, in that it assisted them to work through their physical symptoms of grief:

“I believe that work actually helped me because when I put on my blue nurse pyjamas, I put on my nurse self, the sadness was there but not in an openly physical way” (RN#52)

“Going back to work was good for me and although I did experience many tearful moments, it was outside work hours” (RN#59)

Question 29 – Psychological symptoms of grief

In this question, nurses were asked about their psychological grief symptoms. Sixty nurses replied with a wide range of symptoms identified. The most commonly experienced were the inability to stop thinking about the loved one who had died (described by 58% of respondents, n=35), difficulty in concentrating (42%, n=25) and being easily distracted (42%, n=25). All other psychological grief symptoms were experienced by at least 22% of respondents, including difficulty in making decisions, impaired memory/recall of information and things happening around the nurse that went un-noticed.
Some nurses describe their struggle to maintain psychological equilibrium:

“[I was] unable to think laterally or multitask” (RN#68)

“Less motivated to ensure safe and timely discharges” (RN#10)

“Rumination, irritability and dissociation” (RN#49)

One nurse states that the impact of her father’s death had a positive effect upon her psyche:
“I wanted more work. I wanted something positive to focus on and to be able to make a difference to the people who came in for care and treatment” (RN#69)

Question 30 – Emotional symptoms of grief

Respondents’ experience of emotional symptoms of grief, were explored in this question. An overwhelming 82% (n=50) of the responding 61 nurses, felt a sadness/yearning for what had been lost whilst 38% (n=23) experienced a sense of numbness or of feeling empty inside. Many nurses also experienced anxiety (34%, n=21), anger (30%, n=18), guilt (30%, n=18), and loneliness (26%, n=16). Respondents express anxiety with regard to the future:

“What the future [would be], now it would be different” (RN#64)

“Uncertainty re future family relationships” (RN#49)

Some nurses express the dilemmas experienced, through their desire to respond to both family and work needs. In some circumstances, this was compounded by a geographical isolation from family. Comments made to multiple questions have relevance to this matter:
“Feeling unable to support my own children going through their grief as well. Feeling guilty about being at work and not at home” (RN#26)

“Guilt because as a nurse I could have done more but distance made it hard” (RN#29)

“I had demands from family re Dad’s house and lawyers demands etc and could not get time off for sorting this. This caused a rift with sibling. I felt pulled in different directions, I was not able to get time off for two months which became a big issue” (RN#30)

**Question 31 – Spiritual symptoms of grief**

The final in this series of four questions exploring the symptoms of grief, asked about spiritual symptoms. Forty-two responses were received to this question. A number of nurses describe searching for meaning in life (36%, n=15), whilst others were unable to make sense of life (33%, n=14). Some nurses express having new insight into the finite nature of life:

“That this was the circle of life” (RN#35)
“I realised that everyone has to go one day and to make the best of it” (RN#32)

“Realisation of how short and fragile life is, [I have] experienced this before in nursing but never so much as when my parent died” (RN#19)

Two nurses express a heightened spiritual connectedness:

“I actually felt more spiritually connected” (RN#69)

“Day dreaming: gazing at the room [in which my mother-in-law died]. Personal spiritual encounters (I had to work in the same room two days afterwards)” (RN#8)

**Question 32 – Impact of bereavement upon ability to work**

In this open response question, participants were asked to comment upon the statement ‘my bereavement experience impacted upon my ability to work in the following ways’. Forty-five nurses chose to write of their experiences in this regard, and these comments have been organised into the same structure as used for questions 28-31 (that is, physical, psychological, emotional and spiritual impacts).

**Physical impact**

Seven nurses describe their work being impacted physically by bereavement, with four of these saying they were frequently tearful:

“[I was] emotional and tearful most of the time” (RN#70)

“I would cry easily” (RN#9)

Other nurses describe fatigue, tiredness and decreased energy as being an issue for them in their roles, with one nurse indicating the energy and work involved in trying to recover from her bereavement:

“It is hard trying to get back to normal and trying to be the person you were. I was very tired, I was sad but I tried to be stoic” (RN#55)

**Psychological impact**

Thirteen nurses indicate their bereavement had significant psychological impact upon their ability to work. Many describe an inability to focus, concentrate and multi-task, resulting in a disorganised approach to work and poor time management:
“Jobs that would normally take me minutes seemed to take forever, for example reading patient notes, I would read them through and not remember what I’d just read and have to start all over again” (RN#51)

A number lost confidence in their decision making and critical analysis abilities:

“I doubted my decisions in the care of patients” (RN#18)

Some describe a lack of motivation, enthusiasm and drive, whilst others state they were disinterested in people around them. A number of respondents indicate their ability to communicate effectively with others was impacted, resulting in impaired teamwork:

“I had a disinterest in people around me and [found] it hard to interact with anybody. I would hardly talk” (RN#70)

“No team work. Not communication to colleagues as usual [sic]” (RN#65)

“Planning and following through on plans and keeping in contact with colleagues about issues” (RN#64)

One district nurse describes her memory as being effected by her loss:

“I lost my phone and misplaced by diary during this time” (RN#64)

One nurse notes a decrease in her job satisfaction however, another describes an increased sense of accomplishment through working during this bereavement time.

Emotional impact
Fourteen respondents describe their bereavement as having an emotional impact upon their work. Six nurses attest to experiencing a sense of anger or bitterness towards patients and co-workers, whilst others indicate a lack of empathy for others circumstances:

“I felt angry that this major thing had happened to me and yet nobody ever asked me how I was doing, was there anything they could do to ease the pain” (RN#69)

“I was angry at patients who were struggling with being unwell – they were alive and had a chance to turn their lives around, my friend was not. I had to try really hard to not be rude to them” (RN#22)
“Anger that people were so demanding of me. Often thinking to myself ‘don’t they know I’m dying inside?’” (RN#51)

“For a while I felt less compassion and empathy for others” (RN#19)

“I did not feel real compassion for others – paid lip service” (RN#4)

Interestingly, other nurses felt an increased empathy towards their clients, following their bereavement experience:

“I found I had more empathy with patients who were nearer death” (RN#64)

“It has impacted my ability to provide empathy, in a positive way. I have more of an understanding of what clients, their families and friends are experiencing. I listen more” (RN#37)

Others describe an overwhelming sense of detachment and loneliness, from both patients and team members:

“Despite considerable support from colleagues, I felt isolated and often lonely” (RN#44)

“I wasn’t very open to my patients” (RN#21)

Yet other nurses describe their bereavement as impacting on their work, through an increased sense of guilt, anxiety (especially in crisis situations), sadness and a lack of patience, particularly with stressful team dynamics.

Spiritual impact
No nurses attest to any spiritual impact upon ability to work, following bereavement.

Interestingly, some nurses offer insight into the strategies used to mitigate their grief. A number acknowledge the use of avoidance, particularly of palliative patients, or those with a similar diagnosis as their loved one who died:

“I tried to avoid caring for people who were actively dying, for the next couple of weeks, as I felt I would cry easily ... it was easier to work where I wasn’t surrounded by other’s grief” (RN#9)
One nurse admits to “shutting everybody out and turning to alcohol” (RN#16) in order to cope with the pain of grief, whilst another nurse was forced to change her work contract due to increased child care obligations.

**Question 33 – Sick leave**

Participants were invited to indicate the extent to which they utilised sick leave upon returning to work from bereavement leave. Of the 64 nurses who responded to this question, 30% (n=20) either agree or strongly agree that they utilised sick leave during this time frame. Conversely, 70% (n=45) indicate that sick leave was not taken.

![Figure 50](RN Question 33) Sick leave.

**Question 34 – Experience of working**

This question was asked in order to elicit stories or comments that RNs might feel to be significant with regard to working post personal bereavement. Nurses were invited to comment upon the statement “after returning to work, the following situation/s made me think that I wasn’t safe to work after all”. Twenty-six comments were received to this question, which have helped to inform the notable themes particularly that of safety to work, discussed in the following chapter.

**Question 35 to 37 – Suggestions made to improve support for bereaved RNs**

These three questions provided participants an opportunity to express their thoughts of how bereavement support for nurses could be improved. Nurses were asked to make suggestions.
about both beneficial managerial/organisational practices, and practices that would be better avoided. Additionally, they were invited to make any final contributing comments about the research topic. Answers to these three questions provided a rich data set, with a total of 120 comments made. As with the responses to the previous question, these comments have been used to inform the content of the discussion and recommendations, and will be explored in more depth in those forums.

Question 38 – Consent

The Research Ethics Approval and the participants’ study information state that submission of the survey implies consent to participate in it however, participants were asked to confirm their willingness to submit their contribution to the research. Although this question was a mandatory field requiring a response, eight respondents left the survey site prior to this question. All participants who provided a reply to this question gave their consent for all information to be submitted.

Summary of findings from the registered nurse survey

Respondent demographics reflect those of the total New Zealand RN workforce (Nursing Council of New Zealand, 2014), with a large majority being over 40 years of age (respondent median age 40-49 years). Most of the RN cohort identify as being of Pākehā (New Zealand European) descent, with other European ethnicities, Pacific Islanders, New Zealand Māori, Asian and African nurses also participating. The RN respondents are a highly experienced workforce, with a median of 20-29 years of nursing experience, with nearly all respondents being familiar with their roles and departments at the time of their bereavement. Nearly three-quarters of the participants experienced the death of a first degree relative (primarily the death of a parent) with over half of the deaths being unexpected and with one-fifth of them resulting from traumatic causes. The vast majority of these nurses describe their relationship with the one who died as either close or very close.

When the responses to this survey are reviewed as a whole, some concerning themes arise, that demand further discussion. Despite nursing being a caring profession, significant numbers of RNs feel they were not treated with either respect or compassion by their managers and many describe feeling unsupported by their nursing leaders when recommencing nursing duties. Nearly half of the respondents indicate that their manager did not communicate well with them during their bereavement experience, and did not understand their particular
needs, or those of their family. When the data are analysed from a cultural perspective, those identifying as non-Pākehā (non-New Zealand European) feel this lack of support more acutely. Over one-third of nurses felt unsupported by their manager when returning to work, whilst the majority felt supported by their colleagues during this time. Registered nurses perceived that managers assisted them to work out leave entitlements only half of the time, despite three-quarters of RNs not knowing the presence or content of organisational policy to assist with this. Similarly, more than half of respondents feel they were not offered professional support services, despite all three participating DHBs employing independent counselling services that are gratis to the employee. Virtually no organisations offered RNs written bereavement resources to help them understand what they were experiencing.

Of significant concern, is the finding that the majority of nurses feel that no discussion was entered into with their manager regarding their safety to recommence nursing duties, and nearly one-third feel that their manager did not listen to the concerns they had about returning to work. Of further concern, is the finding that over one-quarter of nurses believe they were unsafe to work and over one-third describe adverse impacts upon critical analysis skills at the time of resuming nursing duties. Flexibility in work options and patient care loads, were generally not offered these bereaved nurses transitioning back to the workforce.

Nurses describe the presence of a wide range of grief symptoms upon return to work, all having the potential to affect work practice, and to influence client, nurse and organisational safety. Of particular concern is the prevalence of the symptoms of fatigue, tearfulness, insomnia, difficulty in concentrating and making decisions, impaired critical analysis skills and memory, disinterest in people or events and being easily distracted. Many of these symptoms may relate to the commonly found symptom of being unable to stop thinking about their loved one who had died. The majority of nurses experienced sadness and a yearning for what had been lost, with many describing symptoms of anxiety, anger, guilt, emptiness and loneliness. The inability to make sense of life and searching for meaning in life was common in these bereaved nurses.

**Chapter summary**

In this chapter, findings from both NM and RN surveys have been presented. Both cohorts of participants have provided useful insight into aspects of RN bereavement care and support. When survey results are compared, consistencies and discrepancies are noted.
Although the NM cohort has a narrower age distribution and a higher median age than that of the RN cohort, the number of years of nursing experience is the same for both groups of respondents. The majority of respondents are familiar with their current roles, with over 90% of each cohort having been in their current roles for more than two years. There is general agreement that there are policy gaps within organisations to assist in meeting the needs of both bereaved RNs and NMs. One collective concern is the recognition of a need for additional leave beyond that stipulated by legislature for a nurse who has been bereaved. Both cohorts describe variability and inequity in the approval of leave. Despite many RNs reporting ongoing physical and psychological grief symptoms affecting their decision making and critical analysis skills, there is widespread acknowledgement from both responding groups that little consideration is given to a nurse’s safety to work prior to the resumption of duties. Each of these common issues will be explored further in the discussion chapter.

There are areas of discrepancy between NM and RN responses that are also worthy of further discussion. The majority of NMs feel that they manage bereavement care within their departments well and despite an acknowledged absence of professional development on this topic, most NMs feel confident with supporting bereaved nurses. All NMs indicate they offer bereavement care in a culturally appropriate manner and the vast majority state they always offer professional support services to bereaved RNs. However, significant numbers of RNs describe the absence of respect and compassion, of not having their concerns listened to or acknowledged and of experiencing variability in communication on the part of their manager. Feeling unsupported upon return to work was frequently commented on by RNs, with many expressing they were expected to, ‘get over’ their grief and ‘get on’ with work. The offer of assistance to access professional support services was the experience of less than half of the RNs. These consistencies and discrepancies have been grouped into four themes that will be discussed in the following chapter.
In the previous chapter, the research findings have been presented in graphical and written form. It would appear that the respondents welcomed the opportunity to comment upon the topic of bereavement care for nurses, as an abundance of data were collected. There are commonalities and discrepancies in responses from the two cohorts. Common findings include inadequate policy to address leave entitlements, which contributes to considerable variability and inequity in leave approval. The need for leave that is additional to statutory requirements is highlighted by both cohorts. Similarly, both groups acknowledge that assessment of RN safety to work rarely occurs. Differences in findings are seen with regard to the quality of current bereavement support for RNs, with the majority of the NM group indicating that despite a dearth of training on this matter, they believe they manage bereavement care well and with confidence. Many of the RNs surveyed however, disagree. Areas of concern raised by the RNs relate to lack of respect, compassion and support from NMs upon return to work. Additionally, variable NM communication strategies and the expectation that the grieving nurse will resume work at full capacity were seen by the RNs as problematic. Study findings highlight an ongoing presence of grief symptoms for many RNs returning to work however, the concerns of these nurses were not always acknowledged.

This chapter will review the emergent themes from the study. Because of the number of themes identified, a comprehensive review of all themes arising from this study is beyond the scope of a 60-credit Master’s thesis, and for this reason only four of the most commonly mentioned themes are discussed in depth in this chapter. These themes will also be analysed for publication after completion of the thesis. Those themes not addressed here are left to serve as a pool of topics worthy of further research.

The four themes chosen for discussion are:

1. The limited organisational policy to assist NMs to support bereaved nurses
2. The disconnect between NM perceptions of bereavement support provided, and those of bereaved nurses
3. The lack of consideration given to the bereaved nurse’s safety to work prior to the recommencement of nursing duties
4. The incongruity between managerial attitudes and practices in relation to grief and contemporary models of bereavement
1. The limited organisational policy to assist nurse managers to support bereaved nurses

The traditional purpose of policy development in large businesses is to outline company philosophy/mission and to promote strategies that improve consistency of practice in meeting organisational goals (Isaac, n.d.). Policy development in New Zealand DHBs is an integral component of healthcare delivery and must be in alignment with central government health policy (New Zealand Government Ministry of Health, 2014). One of the aims of this research is to establish the extent of existing policy and practice regarding bereavement support for RNs working in the role of staff nurse, in secondary and tertiary healthcare services in New Zealand. Findings indicate that some DHB policy exists that provides guidance to NMs supporting bereaved nurses, however gaps within policy were also found.

Content of existing policy

The majority (70%) of the NM respondents acknowledged the presence of some policy within their organisation to assist with the issue of bereavement support. When content is explored, it appears these policies principally relate to paid and unpaid bereavement leave entitlements, and to accessing professional support, rather than a process for supporting a return to work for bereaved staff. Given New Zealand’s employment law stipulates the minimum provision of paid bereavement leave following the demise of a first degree relative (New Zealand Government, 2013), the presence of such policy is unsurprising and is likely driven by the organisational need to ensure managers uphold legislative requirements. Similarly, the presence of policy regarding accessing professional counselling services for bereaved RNs, could be anticipated. Each of the three participating DHBs employs independent professional counselling services via EAP, offered gratis to employees in need. However, it is concerning that only 48% of the total NM cohort knew of this policy, which may inform the inconsistency of RN experience with regard to the offer of professional counselling services for bereavement support.

Interestingly, nearly one-quarter of managerial participants do not know if their organisation has any bereavement policy, despite all respondents in the ‘don’t know’ cohort having extensive years of nursing management practice. Nurse leaders are required to navigate a multitude of increasingly competing demands (Rosenblatt & Davis, 2009). For this reason, it could be that leaders operate on a ‘need to know’ basis, only searching out the presence of policy when specific circumstances arise. However, not only are each of these ‘don’t know’
respondents experienced team leaders, each has recent experience of supporting a bereaved RN. Thus despite this very issue having been a part of their leadership practice in the previous 12 months, it would appear a search for pertinent policy was not undertaken or policy was not found. This paucity of policy usage related to bereavement, lends itself to suggest that bereavement care in clinical practice is not well supported and/or is an area of little consequence in management practice. There appears to be a lack of consideration given to this issue as a management focus.

**Gaps in existing policy**

With findings similar to those of McGuinness (2009) presented in the literature discussion, this research identifies a number of gaps within organisational policy with regard to bereavement care for nurses. Although leave entitlement following the death of a first degree relative is generally addressed within policy, it would appear there are grey areas at the boarders of legislature, about which policy is silent. Following a search of the legislation it was found that New Zealand law requires the employer to ‘give consideration’ to paid leave upon the death of an extended family member when the employee has experienced a close relationship with the deceased, is required to attend to any aspect of the funeral ceremonies, or has particular cultural responsibilities with regard to the death (New Zealand Government, 2013).

Participating managers in this study comment upon the lack of policy to assist with this decision making, for example, one respondent noted:

“[Organisations] need to be more specific about bereavement leave. Does an uncle that they haven’t seen in years count for bereavement leave? Currently we have no guidance on what we can offer. How do we as managers make the call on what bereavement leave is appropriate and for how long?” (NM#5)

A further policy gap is apparent in relation to the granting of bereavement leave when the deceased is other than a family member. New Zealand legislature is somewhat muddy with regard to this, essentially putting the onus on the survivor to convince their employer of their bereavement. The employer is obligated to “allow the employee to take one day of paid bereavement leave on the death of any other person [than immediate family member] if the employer accepts that the employee has suffered a bereavement as a result of death” (New Zealand Government Ministry of Business Innovation and Employment, 2012, para. 1).

Unsurprisingly, variability is seen in approval of leave in these circumstances. One nurse whose close friend died expressed doubt that her bereavement leave would be approved however, her manager granted it without question, and this was perceived by the nurse as
being “so supportive” (RN#37). However, this was not the experience of other nurses. One nurse requests to make this point on behalf of all immigrant nurses:

“Most of us have our immediate family members abroad and our immediate family here in Aotearoa [New Zealand] are our significant groups that we identify with, for example, church groups. We should be allowed to take bereavement leave when someone in this group dies so that we can grieve with their families as we call the Church our family [sic]” (RN#29)

Another RN states:

“There are some people in our lives who are very special and once they die we should be given compassionate leave for them as well” (RN#32)

These findings challenge the historical belief that regards the death of a friend or colleague as having a lesser impact on the survivor than the loss of an immediate family member, as highlighted by Holland et al. (2006). Current policy and comments from RNs additionally demonstrate the outdated concept of a ‘sliding scale’ of bereavement support commonly based upon genetic relationship to the deceased, which is presented in the literature search chapter. When taking this approach, the managerial response to a bereaved person is strongly influenced by the manager’s perception of the bereaved’s closeness to the deceased, as well as the manager’s own values with regard to death, family and community, and their perception of the employee’s commitment to the organisation (D. Hall et al., 2013). As previously discussed, contemporary concepts of sense-making and benefit-finding are instrumental in a survivor’s adaptation to their loss (Holland et al., 2006). The above quotes from the data illustrate the significance of the interplay that has been identified in other research, between the survivor’s depth of connection with the deceased, the search for meaning triggered by this life-changing event and the ability to find benefit in the situation (Neimeyer & Sands, 2012). The anticipated death of an elderly grandparent may for example, not precipitate in the survivor a search for meaning, and despite a close loving relationship prior to death, the survivor may find benefit through increased family connectedness and in the knowledge that suffering related to infirmity has ceased. Following the premature death of a close friend or colleague, however, the survivor may struggle to make sense of the situation at a pragmatic level (what happened?), an interpersonal level (how does my friend’s death effect who I am?) or a divine level (why has God permitted this tragedy to occur?) (Neimeyer & Sands, 2012). Helpful policy that provides guidance for managers on this grey area could focus on the degree to which sense and benefit are to be found, the impact of the
death on the survivor’s psyche and the emotional closeness of the prior relationship rather than on the genetic relationship alone.

Some leaders comment upon the lack of policy to mitigate the dilemma faced when granting bereavement leave beyond the legislated three days that appears to unfairly discriminate against nurses from a New Zealand European heritage:

“It is very unfair that people from [some cultures] are allowed more paid bereavement time than other cultures” (NM#5)

“Bereavement leave needs to be consistent for all staff. [Some cultures] tend to have more leave due to cultural needs whereas European staff [sic] feel they can take one to two days only” (NM#14)

Although these comments could be regarded as a request for equity of leave, they could also be viewed as plea for additional compassionate leave for all nurses regardless of culture. In Trimble’s (2010) study, bereaved employees stated a need for longer than five days paid leave. Many respondents in this study similarly feel that the legislated three days bereavement leave is insufficient for any bereaved nurse irrespective of cultural heritage:

“Give us more time off” (RN#22)

“We should have more than a week for bereavement for close family” (RN#70)

“Offer sick leave once the ridiculous amount of three or four days of bereavement leave is used” (RN#35)

These comments are supported by NMs:

“Organisations need to be more flexible with leave following a bereavement” (NM#5)

“I suggest the duration of bereavement be extended [to] five days instead of three in certain circumstances” (NM#31)

Although no conclusions regarding the perceived inequitable approval of bereavement leave for nurses from differing cultures can be drawn from this study, it is clear that NMs experience distress with the current lack of guidelines.

The approval of bereavement or special leave that extends beyond statutory requirements needs to take both a supportive and a risk management approach, considering strategies beneficial to the grieving nurse, the public and the organisation. Although the duration of
bereavement leave considered to be sufficient for supporting the bereaved nurse and decreasing organisational risk is not clearly outlined by the research, there does seem to be evidence from this study that suggests current entitlements are inadequate. Whilst recommending an increased duration of compassionate leave, it is not suggested that this leave be infinite or unlimited in nature. It is important that organisational interests are also considered in the equation, and that DHBs are safeguarded from any potential abuse of bereavement or special leave allowances. Furthermore, unlimited compassionate leave may not be in the best interests of the grieving nurse, given comments from some RNs in this survey who attest to work as being a positive moderator of their grieving journeys. Thus, policy that provides NMs with flexibility to support bereaved RNs to a certain point, beyond which negotiation at a managerial level higher than that of NM, is recommended. These and other suggestions will be discussed in more depth in the next chapter.

Additionally, there appears to be little policy guidance provided for managers on how to talk with and support the bereaved nurse. The findings of this research support studies undertaken in alternative work environments and discussed in the literature search chapter (D. Hall et al., 2013; Trimble, 2010) and indicate that bereaved nurses display a diversity of psychological and behavioural responses to bereavement. Similarly, the needs of bereaved nurses are heterogeneous and complex, with respondents indicating that a unilateral approach to bereavement care is unhelpful. At the same time, NMs describe a sense of helplessness as they feel constrained by diminishing organisational resources. A management response that is mindful of and sensitive to differing needs of the bereaved nurse could be enhanced by the provision of an organisationally endorsed range of practical strategies for supporting a bereaved RN. One useful strategy could be the mandatory requirement for all bereaved RNs to attend a free consultation with a trained grief counsellor for both support and for the assessment of safety to work. This recommendation is discussed in more depth later in this chapter, whilst other recommendations will be presented in the following chapter.

The impact upon other team members, in relation to a nurse’s bereavement, is another consideration that does not appear to be discussed in policy. In financially constrained health environments, there may not be the availability of bureau staff to back-fill the RN taking bereavement leave, thus placing an increased pressure on remaining team members to provide patient services. Although such a ‘short staffing’ situation may similarly result from other types of leave requirements, such as sick or maternity leave, a staffing shortage precipitated by bereavement leave arguably has the potential for greater impact on the team, given the remaining nurses may themselves be affected by their colleague’s bereavement
through close collegial relationships, or the deceased being known to multiple team members, particularly in provincial communities. Additionally, the experience of the deceased themselves being one of the healthcare team was the experience of some study respondents. Such a tragedy would raise unique staffing needs and requirements for organisational support. Policy that provides helpful strategies to meet these types of situations could also be valuable.

Less than 20% of NMs indicate the presence of an organisational repository of written bereavement resources available to assist RNs in understanding their experiences of grief. Although some study respondents indicate no desire for bereavement resources, others state that a toolkit to assist with adjustment to the ‘new normal’ post bereavement would be beneficial. All resources would naturally require analysis for usefulness, authenticity and validity.

Each of these policy gaps serves to potentiate the sense of helplessness or moral distress alluded to by NMs in this study. This finding of moral distress in NMs who are left unsupported in their decision-making, mirrors those of Maxim and Mackavey (2005) presented in the literature search chapter. Desiring to ‘do their best by’ their bereaved employee, whilst continuing to juggle the needs of co-workers and productivity targets, can cause a dilemma for managers (Maxim & Mackavey, 2005). The seminal writing of Jameton (1984) describes moral distress as the feelings of disequilibrium and malcontent engendered when one is unable to undertake action known to be morally appropriate due to barriers including lack of resource, time, policy or legal constraints. The risks associated with this phenomenon in nurses have been found to include distancing behaviour, blunting of caring capacity, obliviousness to clients’ needs, miscommunication, anxiety and burnout (Wilson, Goettemoeller, Bevan, & McCord, 2013). Given these known risks, it is imperative that organisations take steps to ameliorate the moral distress felt by NMs in their support of bereaved RNs. Policy that allows the authority regarding leave approval to rest with the NM and empowers NMs in the provision of flexible and responsive bereavement care could go some way to addressing this need. This privilege would necessitate the introduction of comprehensive, survivor-informed training programmes for NMs that endorse contemporary models of bereavement, promote respect and compassion and resource a process of assessment of the bereaved RN with regard to the impact of the bereavement and their safety to work. Recommendations to this effect will be presented.
2. The disconnect between nurse manager perceptions of bereavement support offered and those of bereaved nurses

The research findings of an apparent divide between the NMIs and the RNs perceptions of the quality of bereavement care for nurses in New Zealand DHBs, forms the second theme for discussion. This disconnect is particularly notable in the areas of leave entitlement and the offer of professional counselling. The degree to which nurses are treated in a spirit of compassion and respect and the quality of NM communication, are additional foci of difference.

**Nurse manager perceptions of bereavement care**

Restructuring of the New Zealand health system in recent years has seen the role of NM undergo significant flux (McCallin & Frankson, 2010). Additional to the traditional responsibility of clinical patient care management, contemporary NMs are increasingly responsible for issues of business management including employee leadership and resource control (McCallin & Frankson, 2010). Current models of nursing leadership require NMs to have extensive business and administrative skills as well as aptitude with interpersonal relationships and communication, that take time, training and experience to develop (McCallin & Frankson, 2010). The responding managerial cohort of this study has a median of five to nine years of nursing management experience, with 90% having been in their current role for longer than two years. Whilst length of service or number of years within a nursing role cannot be directly correlated to professional expertise (McHugh & Lake, 2010), an argument could be made that this experienced management cohort has, at a minimum, a moderate degree of familiarity with their roles and responsibilities. Similarly, a degree of familiarity with team members, and exposure to organisational policy and practice is expected. This claim is further supported by the almost universal experience of the respondent NM group of supporting a bereaved RN, with only one manager not having to face this matter in the past year. This degree of experience of bereavement care is not surprising given the finding that nearly one fifth of the total RNs managed by this leadership group experienced a personal bereavement in the previous 12 months.

The NMs responding to this survey largely feel comfortable with their responsibilities with regard to bereavement care for nurses. Although over half of the manager respondents indicate they have not received sufficient professional development with regard to bereavement care, the majority of NMs (88%) indicate they feel confident with providing bereavement support for nurses, and 89% feel they manage bereavement support well.
Variability in registered nurse experience of leave entitlements

However, findings from the RN survey present differing perspectives. Nearly half of the RNs feel their manager did not assist them to work out their leave entitlements in a manner that they found to be supportive. A number of RNs express the need for an expeditious NM-facilitated conversation regarding leave entitlements:

“I would have found it very helpful if my manager had spoken to me about leave options, whilst on leave. After returning to work I decided to change some of the annual leave [taken] to sick dependent leave, and had to pay money back due to the different rates” (RN#59)

“I returned to work the day after my mother-in-law died suddenly, as my colleagues said there was only an entitlement for three days bereavement leave, and the funeral was not going to be until later in the week. So I went back to work so I could have the next few days as bereavement leave” (RN#1)

A few nurses attest to extensive bereavement leave support, while the experience of many others was different, with some seemingly receiving minimal leave. This variability in leave approval reflects the findings of Eyetsemitan (1998) presented through the literature search, who observed that the degree of attachment to, or the closeness of biological relationship with the deceased, is not necessarily reflected in the compassionate leave approved by management. One nurse who requested a day off when her parent died unexpectedly overseas was declined bereavement leave. This nurse subsequently requested annual leave to travel internationally to attend her father’s funeral however, it was more than 48 hours before approval for this leave was granted. Not surprisingly, this RN feels her manager did not support her well.

The common practice enforcing the use of annual leave (rather than special or sick leave) to supplement bereavement leave, when the bereaved nurse was not psychologically well enough to work, is seen by RNs as adversely affecting their bereavement experience:

“I had tonnes of sick leave owing but had to use up my annual leave instead, to have an extra week off” (RN#35)

“I had to fly to Europe and back on only five days bereavement leave, which was used up in travel, so used my annual leave so that I could attend the funeral [of my father] and spend some time with my mother who was grieving” (RN#17)
Other comments indicate discontent with support provided around leave entitlements:

“[Managers] could be more flexible with special leave for sorting out family issues. I had a stressful time before my father died and also negotiating time to sort out lawyers and family obligations following the funeral” (RN#30)

One NM’s comment supports the claims of these RNs with regard to variability in approved leave:

“Each manager working in DHBs has discretion to allow for paid bereavement leave and additional leave that may be required. Not all, however, choose to allow the maximum paid time or additional leave” (NM#27)

This variability in policy interpretation and leave allowance reflects the findings of D. Hall et al. (2013) discussed in the literature search chapter. The discrepancies could be related to a lack of NM authority to make these decisions or a lack of leadership understanding of the impact of bereavement on the nurse. Alternative influences could include the requirement of NMs to balance staffing and budgetary resources in an era of financial constraint (McCallin & Frankson, 2010). It could be argued that the business model adopted by the New Zealand healthcare system has required NMs to focus on finance and organisational operations to the detriment of the caring function of the NM role. This claim supports the findings of Cooke (2006) who describes work intensification for nurses as being the primary adverse influence upon standards of care. Key factors identified with work intensification include requirements associated with increased patient throughput in the face of decreasing capacity and resource, alongside the expansion of NM roles to include management priorities, such as budget resolution (Cooke, 2006). The competing demands of fiscal efficiency and caring can create a paradox for NMs who grapple to reconcile the dual roles of resource manager and caring manager, particularly for those who find they are ‘impotent’ to control factors influencing one or both of these roles (Cooke, 2006; Jackson et al., 2013; McCabe & Sambrook, 2013). This speaks again to the moral distress experienced by NMs previously discussed.

As seen above, one manager comments that additional or special leave is available to supplement bereavement leave yet, she states some NMs are reluctant to approve this. Instead, they appear to promote the use of accrued annual leave to supplement bereavement leave, which is seen by some RNs in this study as being detrimental to their bereavement experience. Whilst this strategy may be a straightforward cost-efficient option for organisations to allow leave additional to bereavement entitlements, consideration needs to
be given to the long-term implications of this practice. Annual leave is essential in engaging in activities that serve to counter physical and emotional exhaustion, replenish resources and promote equilibrium (Kühnel & Sonnentag, 2011). The advantages of increased work connectedness, engagement and productivity for those who take regular annual leave are understood (Kühnel & Sonnentag, 2011). Bereaved individuals, like the general populace, have a requirement for annual leave. Arguably they may have an increased need for vacation in the year following the loss given the disruption bereavement brings to every aspect of life. Poole and Geiger (1999) write that the very nature of bereavement demands that the survivor assimilate to the changed reality of living without their loved one, which requires support, energy and time. Therefore, the precipitous use of annual leave entitlements resulting in the inability to take further vacation in the months to years following bereavement may therefore be short-sighted. This trend could escalate the practice of presenteeism and compound public risk. Similar attention should be paid to the practice of using accrued sick leave to supplement compassionate leave. A more persuasive argument could be made for the aptness of sick leave approval for newly bereaved nurses who are incapacitated by the physical and cognitive symptoms of bereavement. However, the enduring implications of using finite sick leave for this purpose must be considered. Studies have shown that bereaved individuals have an increased morbidity and mortality, with higher associated healthcare costs, for months and on occasions, years following bereavement (Stroebe, Schut, & Stroebe, 2007). Bereavement has been shown to be a correlate of increased cardiovascular, endocrine and immunological diseases, with an increased susceptibility of the griever to external pathogens (Stroebe et al., 2007). When this increased vulnerability to ill-health is over-laid upon the common-place illnesses routinely suffered by most individuals from time-to-time, the need for available sick leave is evident. The inability to take sick leave when unwell, is an additional enabler of the practice of presenteeism (Lovell, 2004).

One recommendation of this research is therefore, that special leave be primarily considered where supplementation of bereavement leave is required. Such an astute use of special leave would likely be a worthy investment in the employee/employer psychological contract (discussed in the next section) and improve the nurse’s sense of emotional commitment to the employing organisation. Any use of sick or annual leave should be considered cautiously as last options, following a process of due consideration of potential consequences. Additional recommendations that serve to address variability in leave entitlement are discussed subsequently.
**Variability in registered nurse experience of professional counselling advice**

Although 90% of NM respondents indicate either agreement or strong agreement with the statement ‘I always advise the bereaved RN about the professional counselling/support available’, only 47% RNs indicate they were offered assistance to access these services. Reflecting De Leon’s (2007) Californian healthcare worker research, many RNs in this study were ignorant of the supports available to them. When examined through the lens of years of nursing practice, nurses with over 20 years’ experience report fewer offers of professional assistance (45%) than nurses with less than ten years’ experience (67%). It could be argued that NMs are in fact, offering this support, but that the acute grief reactions of the bereaved nurse are impacting adversely on the assimilation and recall of this information. Such an anomaly would not be unreasonable given the known impact that bereavement can have on psychological health (Howarth, 2011). Whether this incongruity of RN experience with NM perception is due to poor recall, or due to lack of discussion around this topic is left as a focus for further research. What is clear is the finding that bereaved nurses are frequently not receiving this information in a manner that is empowering to them. Thus there could be value in managers re-visiting this offer of professional aid on multiple occasions, in the weeks and months following bereavement when meaning in life is reconstructed. As Gibson, Gallagher and Jenkins (2010) identify assistance to access bereavement support as a key organisational responsibility, this matter will be re-addressed in the next chapter.

Aside from one offer by a departmental psychologist, and two respondents who received assistance from their occupational health department, all professional supports described by RNs were via an EAP service. Despite some NMs indicating that professional supervision is available for RNs, no RN respondents refer to this option for support. Professional supervision is increasingly offered in New Zealand hospitals and aims to provide a protected environment in which the supervisee reflects upon issues affecting practice, with the primary goal being the pursuit of personal growth and practice improvement (Davys & Beddoe, 2010). As seen in the literature review, Broadbent (2013) cites personal and professional development as positive mediators of the grief process. Professional supervision could thus be considered a helpful alternative support service in assisting the bereaved nurse to reflect upon the impact of loss on their clinical practice. With assistance, the nurse could develop strategies that acknowledge this impact, using the experience of bereavement as a spring-board to personal and professional growth. Whilst currently appearing to be an underutilised resource for bereaved RNs in New Zealand hospitals, an increased availability of professional supervision will be one recommendation from this research.
Variability in registered nurse experience of respect, compassion and communication

A disconnect is also seen between the majority of NMs’ perceptions of supporting bereaved RNs ‘confidently’ and ‘well’, and the RNs’ perceptions of the manner in which they were treated by their managers. Nearly one-quarter of RNs feel they were not treated in a spirit of respect. ‘Respect’ is defined as “politeness, honour and care shown towards someone or something that is considered important” (“Respect”, 2015, para. 2). Interestingly, these data are swayed by the large cohort of RNs with more than 20 years’ experience, 31% of whom feel they were not treated with respect by their NM, as compared to only 9% of nurses working for fewer than 10 years. One nurse who lost her parent says:

“My manager was only interested in the fact that I was to return to work and that I was needed to work extra shifts to cover annual leave” (RN#2)

Some nurses were made to feel their bereavement experience had caused significant disruption to the team:

“In fact I felt that I had inconvenienced the service! Comments from my manager left me with these thoughts. e.g. the team have had to really pull it together whilst you’ve been away” (RN#58)

Similarly this study shows that over one-third of RNs did not experience compassion, that is, they did not sense from their manager “a strong feeling of sympathy and sadness for the suffering or bad luck of others and a wish to help them” (“Compassion”, 2015, para. 1). Notably, 38% of nurses with an extensive work history feel they were not treated with compassion, as compared to 18% of nurses with less than 10 years’ experience. Comments indicate that some nurses feel their loss was of no importance or relevance to their team leader:

“She did not even acknowledge [my loss when] I told her my mother had passed away” (RN#61)

“I am left feeling that my circumstances and family do not mean anything, despite the fact that we had worked together in the same service for years” (RN#58)

Similarly one-third of nurses feel their manager was not supportive of them upon recommencement of nursing duties, with many commenting that their manager appeared to be purposefully limiting direct contact with them. One nurse who lost her sister as the result
of a traumatic accident comments about what she perceives as evasive behaviour and lack of help from her manager:

“After her initial hello and how are you, it was like she was avoiding me. I felt that she didn’t really want to know how I was doing, because then she might have to do something to help me and she didn’t want that extra hassle in her already busy schedule” (RN#21)

For another nurse whose sibling died through suicide, this experience of avoidance was accompanied by a degree of hostility from her team leader:

“My manager ignored me on my return to work and actually became very confrontational towards me that I had spoken to the ACN [associate charge nurse], not her, about needing to take time off” (RN#12)

Undesirable managerial communication strategies are also highlighted by the RNs. This was particularly notable for the experienced nurse cohort, half of whom express dissatisfaction with their NMs communication, as opposed to only one-third of the nurses with fewer than 10 years’ experience. Not only is physical avoidance noted, but also avoidance of the topic of bereavement, with minimal and/or no communication frequently commented upon. Even within services where one would expect a high degree of effective communication, this was not always the experience of nurses:

“Everyone was aware my Dad had died and how extremely close I was to him, but I was certainly not asked by my co-ordinator or manager how I was doing” (RN#69)

“I heard nothing at all from her” (following the death of a parent) (RN#2)

“It is hard for them [managers] as they often don’t know what to say and think if they say nothing and carry on as usual it will help the person to forget, but grief shared is easier to bear” (RN#45)

Yet another nurse experienced third party communication, saying:

“No communication from [my manager]. It was the PA [personal assistant] who communicated” (RN#40)

To add weight to these comments, 31% of bereaved nurses feel their concerns about returning to work were not listened to or acknowledged. A perceived managerial disinterest in
individual circumstances was a common theme, and nurses express that they felt pressured to return to work. One nurse who unexpectedly lost her spouse comments:

“My manager called me several times to ask when I could come back to work. I approached my manager about my shifts as I was doing predominantly afternoons and needed to be at home for my children … at the time I returned to work I was told I would have to work all the p.m.’s rostered. This was seriously difficult” (RN#23)

These nurses’ comments indicate that some NMs approach bereavement care using avoidant or laissez-faire leadership styles. Three types of avoidance responses in leaders have been described: placating avoidance in which the NM initially appears to be concerned about a matter, but over time takes no action; equivocal avoidance in which the leader responds in an ineffective manner to a concern as full acknowledgement may require escalated action; and hostile avoidance whereby the leader perceives the team member themselves to be the issue (Jackson et al., 2013). Little is known about the nature of avoidant leadership in the clinical setting (Jackson et al., 2013) however, the findings of this study indicate that bereavement care is one area in which avoidant leadership styles are used by some NMs. Jackson et al (2013) suggest moderators that may influence leaders to default to avoidant leadership strategies, such as over-riding organisational interests, or increasing work demands that promote avoidant leadership as a survival strategy. Regardless of causative elements, avoidant leadership, far from being benign, has the potential to undermine trust and disempower a team (Jackson et al., 2013). Avoidant leadership strategies with regard to bereavement care must therefore be challenged and addressed.

This study shows that despite overwhelming NMs’ perceptions that they confidently manage the care of bereaved nurses well, only 65-75% of bereaved nurses experienced what they perceive to be respectful, compassionate, supportive bereavement care from their nursing leaders. The factors influencing these data, and the reasons for the variability of perceptions between nurses of differing work experience, cannot be ascertained from this study. Similarly, whether this is reflective of perceptions of these nurses regarding all aspects of managerial support, or whether this finding is unique to the experience of bereavement, is unknown and would make an interesting topic of further research. However, causative or influencing factors aside, should a 65-75% ‘success rate’ in bereavement care, as perceived by the recipient of the support, that is the bereaved nurse, be considered commendable for a healthcare profession that prides itself on the tacit values of courtesy, kindness and empathy (Kourkouta & Papathanasiou, 2014)? In a profession that wishes to be lauded as being
responsive to the needs of the individual, and whose workforce understands the importance of effective communication strategies regardless of the practice setting (Kourkouta & Papathanasiou, 2014), is it acceptable that up to one-third of bereaved nurses do not have their needs considered?

As already discussed, professional nursing practice is the embodiment of the core values of “care, compassion, competence, communication, courage and commitment” (Cummings & Bennett, 2012, p. 8). If a quarter to a third of patients were to report a lack of care or compassion on the part of their nurse, or described unwillingness in their nurse to listen to their concerns, the profession would rightfully decry and censure the nurses, management and organisations involved. This is reminiscent of the quality of patient care within the Mid Staffordshire National Trust publicly denounced by Francis (2013). The responsibility for the failure to provide care that was sensitive to patient needs was laid at the door of nursing and organisational management (Francis, 2013). It could be argued that given the findings of this study, the words ‘bereaved nurse’ could be substituted for ‘patient’ in the previous sentence, and those bereaved nurses who experienced a lack of respect, compassion, and whose voices were silenced, have experienced a failure of care similar to that of the patients of the Mid Staffordshire district.

McCabe and Sambrook (2013) describe the potential impact on both nurse and organisation when nurses perceive that they are not recognised or valued. Each nurse holds a set of subjective beliefs about the nature of the reciprocal relationship between themselves and their employer, known as a psychological contract (McCabe & Sambrook, 2013). Central to this contract is the nurse’s perception of being of value and worth to the organisation. Perceived breaches of the psychological contract have detrimental effects on the nurse’s mindset, commitment to their employing organisation, on job performance and to a lesser extent, on their commitment to nursing as a profession (McCabe & Sambrook, 2013). Nurses who sense they are being treated more as a commodity than a cared-for, valued staff member have a higher tendency to seek alternative employment. This in turn, is costly for both the nurse and organisation and ultimately impacts upon the quality of patient care delivery (McCabe & Sambrook, 2013). Crucial to honouring the psychological contract for RNs, is managerial communication that reflects a mutual appreciation of the particular needs and requirements of the nursing workforce (McCabe & Sambrook, 2013). Findings from this study highlight the potential for damage to this contract through a lack of respectful and compassionate communication and care for bereaved nurses.
Study findings thus support those found through the literature search and discussed in that chapter, that as the immediate team leader, the NM plays a pivotal role in the RNs practice experience following bereavement (DeLeon, 2007; D. Hall et al., 2013; Trimble, 2010). Registered nurses in this survey experienced variability with regard to the provision of compassionate leave, support to access professional counselling services and communication that portrayed respect, compassion and care. It is acknowledged that contemporary nursing practice must increasingly be undertaken within a milieu of economic constraints requiring innovative healthcare strategies to keep pace with service demands (Matheson, 2013), however, neither respect, nor compassion, nor effective communication are fiscally dependent. An empathetic approach to bereavement care that focuses on listening to, connecting with and acknowledging grieving nurses, would display the cost-neutral humane values identified by Alimo-Metcalfe and Alban-Metcalfe (2005), as the key elements of effective leadership, that is, an awareness of others’ needs and a concern for their welfare. This will be discussed further in the next chapter.

3. The lack of consideration given to the bereaved nurse’s safety to work prior to the recommencement of nursing duties.

The third most commonly mentioned theme from the data concerns assessment of RN safety to work. It is understood that the experience of bereavement impacts upon a person’s cognitive, emotional, physiological and spiritual well-being, with the extent of grief symptoms being variable for different individuals (Howarth, 2011). As the majority of RN respondents have over 10 years of nursing experience, with more than half having over 20 years’ experience, these acute care nurses, are very familiar with the profession of nursing and are unlikely to be naïve to life and death issues. However, despite this professional intimacy with bereavement, the experience of personal bereavement appears to have far-reaching implications for nurses. One nurse describes the domino-effect of grief on her practice:

“[I had] no extra support, a difficult work environment. Bullying by management about other work issues and later an episode of serious anxiety and depression requiring occupational health input which lead to occupational health seeking department of labour involvement – which turned into further bullying. Effects of grief and loss were never taken into account” (RN#49)
Another nurse felt compelled to seek new employment, due to a management decision that led to her father passing away on the ward in which she worked:

“I could not stay and work on that ward as I kept visualising my father sitting in the four bedded cubicle where he was. I left and moved to Australia to start ‘afresh’”

(RN#16)

Such experiences of personal bereavement have ramifications that go beyond the personal health and clinical practice of the nurse alone. There is the potential for adverse consequences at client, organisational, national and professional levels, and whilst it is not possible to alleviate all unfavourable outcomes of personal bereavement for nurses, it is imperative that strategies are developed to mitigate them where possible. One such area is with regard to nurse safety to work after bereavement. Survey respondents were asked about assessment of the RNs safety to work following bereavement, and RNs were asked to indicate the extent of their grief symptoms upon returning to work.

*The extent of assessment of the nurse’s safety to work*

As previously discussed, nurses work within dynamic, challenging environments and need to be able to swiftly retrieve their tacit and formal knowledge and to function with advanced observation, analysis and critical thinking skills in order to provide safe, timely, goal-directed care (McCabe & Sambrook, 2013; Pickett, 2009). It is expected nurses will utilise sound judgement and be able to communicate appropriately with patients, *whānau* (family) and other members of the healthcare team (Leonard et al., 2004). Participants in this study work within New Zealand secondary and tertiary care sectors in which, as with their international counterparts, the patient-care environment is becoming increasingly demanding, with a greater number of acutely unwell patients and decreasing lengths of stay (McCloskey & Diers, 2005). This increasing complexity of the patient milieu adds a growing burden on these nurses to function at a high performance level (McCloskey & Diers, 2005). To add to this stress, the bereaved nurse working in such an environment has the additional burden of ‘layered suffering’ to contend with, as whilst attending to her own grieving needs, she must remain empathetic and understanding of the concerns of the clients being cared for – clients who themselves may be experiencing illness, pain, grief or impending death (Purnell & Mead, 2007).

When ‘duty of care’ is defined as “the obligation to safeguard others from harm while they are in your care” (“Duty of care”, 2015, para. 1), it could be argued that nurse leaders have a moral duty of care to both the public and nursing staff to ensure RNs in their team have the required
skills and attributes to safely perform their work. Furthermore, when a nurse’s abilities are identified as being compromised, having strategies to mitigate potential risk is paramount.

Unfortunately, survey findings show a limited consideration is given to bereaved nurses’ safety to work, with only 18% of NMs stating they undertake some degree of RN assessment. This predominantly involves an informal discourse with the RN, or a request of the RN to self-assess their own safety to work. Safety to work does not currently form part of bereavement care for 82% of managers:

“Not sure. Never knew we needed to assess this” (NM#12)

This finding is consistent with the RNs perspective, in which 83% of RNs indicate they did not have any discussion regarding this issue with their manager. This failure to consistently assess safety to work is a concern, given the extent of grief symptoms experienced by the survey respondents when returning to work, and thus the increased potential for harm, particularly to patients and the nurse. Study findings cannot identify moderating factors in this apparent absence of assessment. It would therefore be interesting to further investigate any potential links between the moral distress described by NMs in this survey and assessment of RN safety to work following bereavement. Further research with regard to this issue is required.

The impact of grief symptoms on safety to work

In the literature search chapter findings from previous studies are presented that evidence the significant impact upon the bereaved’s work performance (D. Hall et al., 2013; McGuinness, 2009; Trimble, 2010). These studies spoke of the diminished competence of newly bereaved employees, of their being overwhelmed by demands, crying and having a decreased ability to concentrate and make decisions. Findings from this study support this prior research with 28% of bereaved RNs in this study stating they felt unsafe when they returned to work, and over one-third testifying that their critical analysis skills were adversely affected. When these findings are explored further, it can be seen that nurses describe themselves as experiencing a wide range of grief symptoms. Of particular concern are the physical and psychological symptoms nurses were experiencing upon recommencement of nursing duties, with significant numbers of nurses describing ongoing fatigue (64%), tearfulness (57%) and insomnia (48%).

Given the surveyed nurses all work within secondary or tertiary care environments and it is likely the majority were working rostered shifts, the sleeplessness and fatigue of shift work needs to be overlaid upon this. The adverse health outcomes for employees working rotating shift work has been researched in depth in past years (von Treuer, Fuller-Tyszkieiwicz, & Little, 2014). Personal bereavement therefore places these nurses at a dual disadvantage, which has
the potential to further increase the already recognised fatigue-related errors and accidents associated with shift work (Wagstaff & Lie, 2011).

Perhaps causing even greater unease is the prevalence of psychological grief symptoms identified by RNs upon return to work. Of particular note are the nearly 60% of nurses who couldn’t stop thinking of their passed loved one, and the large numbers who describe difficulty concentrating (42%), those who were easily distracted (42%), and the smaller but still significant numbers of nurses who indicate poor memory (28%), impaired analysis skills (27%), an inability to notice what was happening around them (25%) and difficulty making decisions (22%). Many nurses provide comments about their cognitive and psychological states:

“I didn’t have the energy to think situations through very well. I would try to work out what patients’ symptoms would mean, but thinking was just so exhausting. I remember once that I called the doctor and made it her problem because I couldn’t think straight. I’m pretty sure I missed a few early signs and once it was only a comment from one of the other nurses about my patient that made me realise my patient wasn’t doing so well. I hadn’t noticed” (RN#21)

“I was slow to react and didn’t read situations very well. I didn’t care much about anything or anyone” (RN#21)

“I suffered from tunnel vision and was unable to critically think or look at the bigger picture for my patients and their families” (RN#3)

“I was too emotionally distracted to function normally” (RN#36)

“I would remove myself from the ward and sit in the toilet to get away from the noise and stress” (RN#30)

Given these are the very skills demanded of a nurse working in a high acuity environment (Pickett, 2009), the type of disruption to cognitive proficiency these nurses describe, regardless of any additional underlying physical grief symptoms such as fatigue or tearfulness, has the potential to increase risk for all stakeholders. One nurse provides an example of this risk, stating, “thank goodness we double check IV medications because I came close to making a few mistakes” (RN#18).

The disruption to physical health and cognitive proficiency described by these grieving nurses is exemplary of the issue of presenteeism discussed in the introductory chapter. Letvak et al. (2012) describe presenteeism as when an employee is physically present whilst unwell, and
identify an increase in risk to the public when this practice occurs. Other researchers have found that key motivators to presenteeism in nursing include the dominant team culture promoting loyalty to co-workers and pressuring the unwell nurse to present for work rather than place increased workload on colleagues (Crout et al., 2005). Similarly, the socialisation of nurses and assimilation of the nurse identity causes RNs to regard their own healthcare needs as being subordinate to those of their clients and further adds to the practice of presenteeism in nursing (Crout et al., 2005). Although moderators of presenteeism with regard to grieving nurses cannot be identified through this research, it does authenticate the practice of presenteeism in some bereaved nurses. A response that recognises this practice and promotes the needs of the individual nurse, whilst providing options for both further leave and then support once leave has been exhausted, is necessary to decrease risk and enhance quality of care.

One cost-neutral strategy to ameliorate this risk could be the routine adoption of a ‘supported practice model’ whereby the bereaved nurse works alongside a mutually decided experienced colleague for an agreed time-frame. Both nurses’ caseloads would be managed as one, with shared critical analysis and decision making, co-checking of medications, and support offered as and when required. This recommendation will be explored further in the following chapter.

The self-assessment strategy

Some managers in this study describe relying on a RN self-assessment strategy, essentially asking the nurse to decide about her own safety to work. As part of an informal discourse, the RN is asked if she is ‘OK’. The findings of this study however, may indicate that this could be a misleading strategy when used in isolation. Upon returning to work, 72% of nurses felt they were safe to work. However, further analysis of these nurses’ responses to other questions in the survey casts doubt on the validity of that assessment, as nearly half of these nurses describe at least one, sometimes all, of the afore-mentioned physical and psychological symptoms of grief, upon recommencement of nursing duties. One nurse, who describes herself as being safe to work, also describes feeling blunted, as having difficulty concentrating and making decisions, with impaired critical analysis skills and anxiety upon return to work, says:

“I never truly felt that I was unsafe because I was supported and the team informed me if they felt I was missing something” (RN#60)

The way in which this nurse was reliant on her colleagues to maintain clinical safety, does not appear to be a concern to her, and this further demonstrates a lack of insight about her
emotional wellbeing at that time. These data indicate that bereaved nurses may not be in the right place to critically analyse and make decisions about their own safety to work, when it is these very skills that are adversely affected by bereavement. Although no direct correlation or causative factors can be drawn from this study, it does highlight a focus worthy of additional investigation.

This research shows the adverse impact of grief symptoms on bereaved nurses’ physical and psychological wellbeing. The high acuity work milieu, the layering effect of bereavement-related fatigue for shift workers and the disruption to cognitive proficiency, can combine to create a ‘perfect storm’ for grieving nurses. A managerial approach that demonstrates an awareness of the potential impact on the nurse, seeks clarification of the nurse’s experience and focuses on effective assessment and communication strategies is recommended. The following nurse’s comment succinctly summarises this:

“[Managers need to] proactively meet with staff to gain understanding of the effects of bereavement and what staffs’ individual needs may be, including accessing external support” (RN#49)

Thus, whilst a NM cannot influence a nurse’s experience of grief symptoms, it is within their realm to mitigate the negative effects of these symptoms upon the nurse’s clinical practice. Through recognition of the potential impact of bereavement upon a nurse’s core values and the development of strategies that assess safety to work, a NM is in a key position to provide a supportive work environment for the grieving nurse. An alternative organisational strategy that could be adopted to assess RN safety to work prior to recommencement of duties, and one that does not rely on the NM being resourced to undertake psychological assessment, is the obligatory attendance of the bereaved RN at a free consultation with a trained grief counsellor as a first line approach, supported by additional strategies, such as time off work if the need is identified. Although there would clearly be resource associated with this type of assessment, the likely decrease in risk to all stakeholders, the reduced incidence of presenteeism in clinical practice, the improved organisational commitment and endorsement of the nurse’s psychological contract with the employer, may result in reduced costs incurred in other areas. Suggestions to this effect will be outlined in the recommendations chapter.
4. The incongruity between managerial attitudes and practices in relation to grief and contemporary models of bereavement

The final theme presented in this chapter arising from the data, is the incongruity between the attitudes and practices of many NMs regarding bereavement care and twenty-first century bereavement models. As discussed in the literature search chapter, contemporary bereavement models have lain to rest the twentieth century concept of ‘moving on’ from grief, that purported a ‘work of grief’ was necessary for the survivor to cleave all emotional bonds with the deceased, lest they fall into mental or physical ill health (Freud, 1917). Similarly, the thought that a grieving individual will follow an anticipated, sequential transition through five stages grief “denial and isolation, anger, bargaining, depression and finally acceptance” (Kübler-Ross, 1969, p. 9), has also been discredited. Critics assert that these models have limited application in clinical practice as they fail to traverse cultural, social and gender divides, or to describe the diversity and complexity of individuals’ physical, emotional, spiritual and social bereavement experiences (C. Hall, 2011).

Stroebe and Shut’s contemporary Dual Process Model of Grief postulates that the bereaved person dynamically vacillates between two modes of coping, with time spent engaging in each mode being variable, even momentary, for different individuals, at differing times. When coping in the ‘loss orientation’ mode, the bereaved’s focus will be on differing facets of the loss, trying to make sense of what has happened (Stroebe & Schut, 1999). However, there will be periods when the bereaved is more problem-orientated and when the focus of coping is external to the individual – the ‘restoration orientation’ mode (C. Hall, 2011). In this mode, the bereaved takes ‘time off’ from mourning, looks for and responds to diversions and forms a new identity distinct from that previously formed when in relationship with the deceased (Stroebe & Schut, 1999).

The concepts of sense-making and benefit finding, as already discussed in this chapter, are additional aspects of contemporary bereavement theory that have impact upon present-day bereavement care. Thus, in contrast with the twentieth century western concept of needing to ‘find closure’ following life-altering events, modern bereavement writers purport that continuing bonds with the deceased can be valuable to optimising survivor functioning (Worden, 2008). C. Hall (2011, p. 9) describes this paradigm shift as reflecting the “recognition that death ends a life, not necessarily a relationship”. 
The expectation of ‘getting over’ and ‘getting back’ to work

Many RNs in this study comment on their NM’s expectation that they ‘get over’, ‘get on’, and ‘get back to full capacity’ immediately following their loss. These comments reflect research previously discussed that attests to a managerial expectation of bereaved employees returning to full productivity directly upon return to work (Gibson et al., 2010). These practices are more reflective of a historical rather than a contemporary approach to bereavement care:

“There is a saying that nurses are not allowed to be sick, and that grieving is a weakness. I feel ripped off that I felt compelled to turn up to work after one day off due to a short staff call from the ACN [associate charge nurse]. In reflection, shame on them” (RN#8)

“A life goes on approach was adopted after the official three days bereavement leave” (RN#57)

“Services were stretched, so it was ‘business as usual’ including overtime and double shifts” (RN#49)

A number of nurses indicate they were expected to manage the care of patients suffering from conditions similar to that which had caused their loved one’s death, or for the care of palliative patients upon immediate return to work:

“Although my manager respected that I had been bereaved, there was an expectation that as I was back to work now it should be ‘business as usual’ without a thought that I was still nursing patients with the same condition that my father-in-law had” (RN#25)

“[I had a] fear of caring for dying patients and re-experiencing the emotions I had for fear of breaking down emotionally in front of my colleagues” (RN#13)

It is perhaps naïve for NMs to believe that a newly bereaved nurse can work in this manner or can undertake overtime or double shifts with impunity. This mind-set disregards the potential for increased risk to all parties. A ‘getting back on the horse’ mentality evidences a lack of consideration of the previously identified concept of layered suffering (Purnell & Mead, 2007) and is based on historical bereavement theory. Leadership strategies that are mindful of these issues could include a nurse-patient allocation that avoids the bereaved nurse taking responsibility for palliative patients or those with particular conditions, for an agreed time-frame. Similarly, flexibility that allows for a temporary reduction in caseload or a phased
return to work would enable the bereaved nurse to transition back to practice in a supported manner. These recommendations will be discussed more fully in the following chapter.

**The expectation that bereaved nurses will have similar needs**

Previous researchers have found that a unilateral managerial approach to bereavement care that ignores the personal circumstances of individuals is perceived as being unhelpful (DeLeon, 2007; Gibson et al., 2010). This blanket approach to bereavement care that anticipates bereaved individuals will have similar needs and will follow a predictable grief trajectory is reflective of outdated bereavement models. Findings from this study illustrate the incongruity between current NM practice and contemporary models of bereavement, with 47% of bereaved RNs feeling that their manager did not understand or give due consideration to their particular needs. This experience was especially noted by the RN respondents who, like the bereaved in Trimble’s (2010) study, found themselves unexpectedly taking on new responsibilities as a result of the bereavement. Comments illustrative of this issue from RNs in this survey describe a lack of managerial consideration of the domestic, financial or travel implications of the bereavement. This was particularly the case when the death resulted in a change of role for the survivor (to the sole carer of dependent minors or elderly parents), when the survivor was required to attend to the dissolution of the deceased estate or when travel was required to attend the funeral:

“She couldn’t empathise with my situation at all and went by the book, sending out official letters to me” (RN#55)

“I needed to travel to get to my sister’s funeral and my manager didn’t seem to understand that I would need extra time off to do this. I also needed time to organise and support the rest of the family as well, not just before the funeral, but after as well” (RN#21)

“I had demands from family re Dad’s house and lawyers demands etc. and could not get time off for sorting this. This caused a rift with sibling. I felt pulled in different directions. I was not able to get time off for two months which became a big issue” (RN#30)

One nurse who experienced the traumatic death of a child in the extended family writes:

“I had an extremely difficult set of circumstances to try to cope with where my family and extended family were polarised and traumatised – and because this bereavement
occurred only six weeks after the death of my and my siblings’ father, everyone in our extended family were already grieving” (RN#49)

As previously discussed, Crookes (1996) acknowledged the propensity for nurses towards complicated grief experiences, as being related to societal expectations of the nurse-relative taking on the role of ‘family nurse’ and the expectation that they interpret health information and care for other grieving relatives. Comments from bereaved RNs in this study show that this phenomenon continues to infer added responsibility and tension for some:

“When you are the nurse in the family, everyone looks to you to be there for them and to explain what has happened. Everyone expects you to be the strong one for them” (RN#21)

“She declined me bereavement leave and I had to take leave without pay for some of the time I had off to go to Australia to support my mother” (RN#12)

The management adoption of outdated bereavement models, in which all sufferers are thought to be on the same journey and therefore receive the same or similar support, is further highlighted when responses from non- Pākehā (non-New Zealand European) nurses are viewed. Despite managers stating they offer culturally appropriate support 100% of the time, relative to Pākehā (New Zealand European) nurses, those from other cultures feel they were treated with less respect and less compassion, their concerns were acknowledged less often.

“I am still not sure how much she knows about my culture and process for grieving” (RN#32)

Causative factors in this incongruity between practice and contemporary models

It is important however, that nurse leaders are not lambasted for this apparent propensity to base their bereavement practice on historical models of loss. Recent New Zealand nursing leadership professional development has followed the dominant international practice of embracing transformational leadership models (MidCentral District Health Board, 2014). Whilst literature widely acknowledges the benefits of transformational leadership programmes in the nursing context, findings from this study would support other expressions of limitations of these models (Hutchinson & Jackson, 2013). Despite extensive use of these leadership programmes, many (53%) of participating NMs describe insufficient training with regard to bereavement care. There thus appears to be gaps within current leadership training and a failure to develop the specific supporter skills required to enter the realm of bereavement care. Wright (2011) attests to the anxiety associated with bearing witness to another’s grief.
He comments that “when moving into the world of a person in mourning, we enter a world of unpredictability, chaos and pain” (Wright, 2011, p. 39). An effective supporter must be a proficient communicator, but also have an extensive understanding of the implications of the experience of unrelenting emotional pain (Wright, 2011). Only then will the supporter understand the sensitive questions to ask and the nature of empathetic dialogue, as well appreciate the behaviours to be avoided. For these reasons, the attributes, specific skills and unique leadership approach required to effectively support a grieving RN, arguably go beyond those emphasised in current leadership training.

Given this lack of training regarding contemporary models of bereavement and bereavement care strategies and the median years of nursing experience of this managerial cohort (20-29 years), the majority are therefore likely to have defaulted to bereavement models taught in undergraduate or hospital training from last century. As described, there has been a large paradigm shift since that time. This need for contemporary bereavement training is a common theme in comments from participants in this study – both managers and RNs alike. These comments display a desire and willingness for practice improvement, whilst reflecting the writings of prior researchers who emphasise the importance of survivor-informed bereavement education for leaders (DeLeon, 2007; Gibson et al., 2010; Ripps, 1992). This need for bereavement training forms one of the main recommendations discussed in the following chapter. Content of these programmes, needs to include contemporary bereavement theory, recognition of the potential impact of bereavement on nurses’ core values, supportive strategies with regard to bereavement and special leave, communication training that acknowledges the bereaved as having particular needs, and strategies that promote a safe return to nursing duties, including RN assessment of safety to work.

Additionally, this study indicates that current organisational structures do not appear to provide the freedom for managers to support bereaved RNs in a way that meets individual needs. Mirroring the findings of Gibson et al. (2010) and Maxim and Mackavey (2005), numerous comments are made by RNs supporting flexibility in work hours and workloads as a proactive strategy to assist with grief recovery. Although 76% of NMs state they offer flexible work hours to RNs upon the recommencement of nursing duties following bereavement, this was the experience of only 22% of RNs. Fewer team leaders are able to offer flexibility of work load, and even fewer RNs had experience of this.

This discrepancy in manager versus RN experience, perhaps speaks of the moral distress felt by managers who desire to meet the particular needs of their grieving nurses, but are in reality,
unable to do so. For these nurse leaders, it appears their sense of wishing to ‘do the right thing’, precipitates a significant moral dilemma. They describe the conflict faced between meeting the needs of the individual bereaved nurse and keeping the department functional:

“We [offer support] the best way we can but sometimes the needs of the service must take priority” (NM#11)

“There is often a problem providing support … while maintaining the service to patients” (NM#1)

“I would like to be able to offer more flexibility in supporting staff to an emotionally safe return to work. I would like to be able to offer reduced hours and workload within a supportive environment” (NM#24)

The extent and degree of this moral distress felt by team leaders will arguably be potentiated over time, with the adoption of contemporary bereavement models, unless organisational structures keep pace, allowing flexibility of management decisions with regard to bereavement care. This will require organisational leaders to recognise the incidence of personal bereavement (nearly one fifth of nurses annually), and the adoption of strategies that enhance NM freedom to support bereaved nurses in an optimal manner. Strategies for consideration include an increase in availability and duration of bereavement and special leave, greater ‘buffer’ within staffing budgets and/or a greater availability of bureau staff to back-fill the nurse on leave, the adoption of more creative rostering frameworks including flexitime, and an increase in temporary, part-time work options. Each of these strategies will be discussed in the recommendations section.

Chapter Summary

Undoubtedly, as immediate team leaders of bereaved RNs, NMs play a pivotal role in the RNs practice experience following bereavement. In this chapter, four themes arising from the research data have been explored. Beyond policy that addresses New Zealand’s legislative requirements for bereavement leave, there appears to be little organisational policy within the participating DHBs, to guide NMs in their provision of bereavement support for RNs. Many gaps in policy exist, particularly policy that provides guidance on leave entitlements upon the demise of extended family members or friends, and the provision of equitable yet flexible leave options for bereaved nurses. Similarly, there appears to be little policy to inform NMs on
bereavement supports available, or that provide practical strategies for communicating with and supporting the nurse and other members of the healthcare team.

The disconnect between the NMs’ perceptions of the quality of bereavement care they provide and the perceptions of bereaved RNs is discussed, including the variability of experience of leave approval (bereavement, special, sick and annual leave). Inconsistency in the offer of professional counselling services and the apparent underutilisation of professional supervision as a method of support is seen. Further explored, are the nurses’ perceptions of a lack of respect, compassion and ineffective communication on the part of their NM. Comparison is made between this failure of care for bereaved nurses with that experienced by the patients of the Mid Staffordshire National Trust, who did not receive nursing care reflective of core nursing values.

The lack of consideration given to nurses’ safety to work upon resumption of duties following a personal bereavement and the potential for risk to all parties is the third theme discussed. The nurses in this study practise in challenging, high acuity environments where the adverse effects of layered shift-related fatigue and grief symptoms, has the potential to severely impact upon safety to work. RNs’ accounts of working whilst continuing to experience a wide range of grief symptoms and their comments regarding the adverse impact of these symptoms on the care provided, evidences the practice of presenteeism in some bereaved nurses. The reliance on the strategy of nurse self-assessment of safety to work is questioned, as many bereaved nurses acknowledge significant disruption to their decision-making and critical analysis skills.

Finally discussion is provided regarding the alignment of NM practices with regard to bereavement care for RNs and outdated models of bereavement. This is particularly notable in the common expectation that bereaved RNs ‘move on from’ and ‘get over’ their grief. Similarly, the manner in which bereaved nurses’ individual needs are not considered is reflective of historical bereavement theory. Few NMs have had the opportunity to undertake recent professional development on contemporary bereavement theory, or to explore the practice ramifications of the recent paradigm shift in bereavement care. Current managerial structures do not provide NMs the freedom to support bereaved RNs in ways that meet individual needs. The moral distress caused for nurse leaders will likely be potentiated over time, unless organisational structures keep pace with current models of bereavement care.

The recommendations and the limitations from this study will now be discussed in the next chapter.
Chapter 6 Conclusions

The emergent themes from the study are explored in the previous chapter. Discussion focuses on four of the most commonly mentioned themes including: the limited organisational policy to assist NMs to support bereaved nurses; the disconnect between NM perceptions of bereavement support provided, and those of bereaved nurses; the lack of consideration given to the bereaved nurse’s safety to work prior to the recommencement of nursing duties; and the incongruity between managerial attitudes and practices in relation to grief and contemporary models of bereavement. In this chapter, research limitations and recommendations are presented, the research process is reflected upon and concluding comments are made.

Limitations of the research

In presenting the findings of this research, a number of limitations are acknowledged. The purposive sampling strategy employed for this study in which three DHBs were non-randomly selected as representative of DHBs nationally, does not allow for research findings to be extrapolated and generalised beyond the realms of these DHBs.

The on-line method of data collection is also recognised as a limitation. Whilst electronic communication is the endorsed method of communication within each of the participating DHBs, the potential remains that this format posed a barrier to some nurses participating due to lack of access to computer hardware or discomfort with this style of communication.

The modest sample size, especially to the NM survey, may have resulted in responses that are not indicative of NM practice throughout the DHBs surveyed. With regard to the RN survey, it is arguable that participating respondents chose to contribute to the research, due to their extremely positive or extremely negative experience of bereavement support. It is possible that those who perceived their bereavement care in a neutral fashion were not motivated to respond. Therefore the RN cohort may not be truly reflective of the experiences of all bereaved RNs within these DHBs.

A further limitation of this research is that the RNs memory or recall and perceptions of events at the time of bereavement may have been influenced by the life-altering nature of the bereavement itself, and may not necessarily reveal the true picture of support offered at that
time. The enormous amount of data received, particularly to the RN survey limited the ability to fully interpret the findings and to address all themes arising from the study.

**Recommendations**

The first field of recommendations relate to the development of organisational policies that mitigate the moral distress experienced by NMs and confer on them the freedom to support bereaved nurses in a manner that is reflective of contemporary bereavement models. It is suggested that emphasis in these policies be given to:

a. Leadership strategies that allow the authority to support bereaved RNs to rest with the NM thereby providing the NM with the freedom to assist all affected healthcare team members appropriately.

b. The precipitous facilitation of a NM-initiated discourse with the bereaved RN upon immediate notification of bereavement. Content of the conversation should include acknowledgement of the loss, identification of the impact of the bereavement and resultant specific nurse needs, leave options, request for permission to share the news with team colleagues and emotional support. Responsibility lies with the NM to approach this discussion in a manner of respect and compassion that endorses the bereaved nurse’s sense of value and emotional commitment to the organisation.

c. Flexibility and augmentation of leave options that decrease the practice of presenteeism in bereaved nurses. In determining appropriate leave allowance, there should be recognition that legislated requirements are frequently insufficient to meet the needs of the bereaved nurse. It is recommended that special leave be the predominant option utilised to supplement nationally legislated bereavement leave entitlements. It is also suggested that sick leave and annual leave be protected and only utilised for the purposes of compassionate leave when all alternative leave options have been exhausted and following negotiation with the bereaved nurse. When approving leave post bereavement, consideration ought to be given to the nurse’s relationship with the deceased, both the genetic relationship and the closeness of the pre-existing emotional relationship. Leave approval should reflect the impact of the loss on the bereaved’s psyche and the degree to which sense and benefit can be found. Any concurrent circumstances of the survivor (for example multiple recent bereavements), or new responsibilities created as a result of the death (for example, the care of minors/elders, estate dissolution), should also be taken into account when deliberating leave approval. Additionally, time-dependent factors such as the need to
travel to attend ceremonies associated with death, should be assessed as part of the decision making process.

Although it is recommended that policy be developed that allows NMs the freedom to approve leave type and leave duration associated with bereavement, it is not suggested that this allowance be infinite or unlimited in nature. It is important that such policy balances the needs of the grieving nurse with organisational interests, and safeguards the organisation from the potential of abuse. It is therefore recommended that requests for compassionate leave beyond a specified duration are required to be negotiated at a managerial level higher than that of NM.

d. Availability of a supplementary buffer within departmental nursing budgets to allow for the incidence of bereavement, recognising that approximately one fifth of RNs will be bereaved on an annual basis. This buffer could take the form of budget-provision for anticipated bereavement and special leave additional to existing sick and annual leave allocations. Similarly, an increased availability of bureau staff to adequately back-fill nurses affected by bereavement would be beneficial.

e. Strategies to assess nurses’ safety to work, prior to the recommencement of nursing duties. This may include the identification of existing, or development of novel grief assessment tools, to support NMs and RNs to identify nurses at risk. It is recommended that such an assessment be obligatory for all bereaved RNs. This appraisal could be NM-facilitated, or out-sourced to a trained grief counsellor.

f. Organisationally endorsed practical strategies that mitigate the adverse layering effects on bereaved nurses caring for patients who themselves may be grieving, and the fatigue-related issues of shift work. Strategies worthy of consideration would recognise the risks associated with the practice of presenteeism in bereaved nurses and could include a phased return to work through the adoption of creative rostering frameworks that allow for flexibility in hours of work and/or workload. Similarly, empathetic caseload allocation for an agreed time-frame that avoids the care of palliative clients and those with particular conditions could be beneficial. One further credible cost-neutral strategy could be the development of a routine supported practice model for bereaved RNs returning to work. In such a model, the grieving nurse works alongside a mutually-agreed experienced colleague, with both case-loads being managed as one. Critical analysis and decision-making could be shared, medications co-checked and support offered in a personalised and timely manner. Such a supported practice model would acknowledge the potential impact of bereavement upon the nurse’s core values whilst establishing a non-judgemental, non-
punitive employment environment that would be influential in maintaining the nurse’s psychological contract with their employing organisation. The duration of this supported practice environment would be flexible, with all parties involved regularly assessing the requirement for its ongoing use.

g. The mandatory offer, on more than one occasion of complimentary professional support services for the bereaved RN. Given the existing structure of EAP within the participating DHBs, it would be prudent to endorse and promote these services. However, the use of professional supervision would provide an additional level of support for bereaved RNs and act as a positive mediator of the grief process.

h. The development and use of a repository of bereavement resources, available to assist with the understanding of the experience of grief. All resources would be vetted for authenticity, validity and usefulness.

The second field of recommendations pertain to the provision of mandatory, survivor-informed professional development for NMs. Such training would be aimed at raising cognizance of the particular issues faced by bereaved nurses, with particular programme emphasis on:

a. Describing the potential impact of personal bereavement on a nurse’s core nursing values. Risks associated with disruption to these values and strategies to mitigate these risks would be addressed.

b. Contemporary models of bereavement and their application to nursing practice. It is important that NMs have an understanding of recent paradigm shifts with regard to bereavement care, and how current models of bereavement could be supported within the professional practice environment.

c. Communication training that empowers NMs to display empathy, respect and compassion. Strategies that coach NMs to listen to, connect with and acknowledge grieving nurses will be key to such a programme. Given the afore-mentioned realm of unpredictability and chaos created by bereavement for survivors, and the sense of unease and discomfort that this commonly engenders in others, interactive education that goes beyond routine communication strategies would be useful.

d. The practical implementation in the workplace setting of the above-mentioned policy recommendations, such as the development of psychological assessment skills including the use of assessment tools.
Reflection on research

Despite the acknowledged limitations with the purposive sampling of three DHBs, this method is believed to have been appropriate for this Master’s level thesis study, given the researcher’s limitations of research experience and resource. Similarly, due to the difficulty of accessing the population of bereaved nurses working in secondary and tertiary hospitals in New Zealand, purposive sampling of nurses working in selected DHBs is seen as the appropriate method of data collection for this study. The use of social media through the leading national employment union for nurses and the academic institution supporting this research provided a useful strategy to increase the response rate. Likewise, the invitation for nurses to ‘snowball’ the research to colleagues within their professional and social networks was beneficial in increasing sample size. Regardless of sample size, as this is a novel topic of research, with little current understanding of the issue of bereavement care for nurses in New Zealand, even these limited findings do provide a valuable snap-shot of care within the three DHBs surveyed.

Strategies that could have been employed to address the limitations of this study could include a comprehensive sampling of all DHBs within New Zealand, inviting both NMs and RNs to participate. Additionally, a clearer focus on fewer fields of interest with fewer questions posed could have enabled a more in-depth exploration of the key issues for both NMs and RNs.

Through the desire to maintain safety for newly bereaved nurses, those whose bereavement was less than 18 months previously were asked not to participate. Despite this, there was a significant response rate from participants in this cohort who felt comfortable participating. Each of these respondents surveys necessitated deletion from the response pool. In hindsight, it would appear that this time frame of 18 months may have been set too conservatively, as responses from a very important and willing cohort of nurses with recent bereavement experience had to be disregarded.

Conclusion

The intent of undertaking this research topic was to explore the current practice and organisational policy with regard to RN bereavement support in the three participating DHBs. Additionally, it was hoped to raise awareness of the experience of bereaved RNs immediately following their loss and the impact bereavement has upon nursing practice. Through this research, issues pertinent to NMs, RNs and their employing organisations have been highlighted and strategies to ameliorate these issues recommended. NM respondents have identified that current policy largely supports national legislative requirements for
bereavement leave following the death of a first degree relative. However, many gaps in policy have been identified, leaving NMs bearing the brunt of bereavement support with little organisational assistance. The moral distress described by many NMs as they struggle to fulfil the operational requirements of their roles whilst maintaining the caring component, is one such issue that requires an organisational response.

Although many RNs describe empathetic, respectful, compassionate support from their NM following their bereavement, this was not the case for a significant number. It is a concern that, in a profession that prides itself on displaying sensitivity, respect and compassion, one-third of bereaved nurses are being failed in a manner reflective of that experienced by the patients of the Mid Staffordshire National Health Service Trust. This research also identifies the disruption to nurses’ core values that a personal bereavement experience can have. Nurses describe a wide range of grief symptoms when recommencing nursing duties and the detrimental effects that these symptoms have on their nursing practice. These comments evidence the practice of presenteeism in some bereaved nurses returning to work. Strategies to improve assessment of RN safety to work and to mitigate the risks associated with working following bereavement are presented and discussed.

The NM has been identified as a key stakeholder in the RNs practice experience following a personal bereavement and plays a crucial role in cultivating the psychological contract of the bereaved nurse, through timely, open communication that demonstrates respect and compassion. Hutchinson and Jackson (2013) describe the potential of the NMs influence, “leadership is positioned as a sense-making process with leaders having the legitimate capacity to shape and interpret the experience of followers” (p. 13).

This research has likely raised more questions than it has answered. If this issue of bereavement care for nurses is to be addressed informatively, further research is required to unpack many of the matters merely touched on here. Studies that investigate the causes in variability of NM and RN perceptions of bereavement care are recommended. Similarly, research that further informs the topic of moral distress in NMs could help to identify if this variability is specific to the issue of bereavement or reflective of other matters where there is conflict between the organisational and caring roles of the NM. Of particular interest, would be research that ascertains the moderators of the practice of nurse presenteeism post bereavement, and studies that examine in depth the risks associated with RNs working at this time. Additionally, there is scope for research to explore factors influencing assessment of bereaved RN’s safety to work. The usefulness of differing assessment strategies could be
studied, including an investigation into the strategy of RN self-assessment that establishes the reliability of this form of appraisal in bereaved nurses. An investigation into the practice of the use of annual leave and sick leave to supplement bereavement leave could focus on the long-term implications of having reduced leave available for the later renewal of body and mind. With regard to the use of professional support services, studies that investigate the barriers and enablers to accessing these services and others that evaluate the worth of EAP and professional supervision in clinical practice would further inform this topic of bereavement care.

Ultimately it is hoped that this research stimulates debate regarding bereavement support within clinical practice. It would appear that bereavement care has been overlooked as a topic of interest within New Zealand DHBs. As Benjamin Franklin succinctly reminded us death is a universal phenomenon, “in this world, nothing can be said to be certain, except death and taxes” (Gigerenzer & Goldstein, 1999, p. 75). The need for bereavement care will therefore not go away, and taking a ‘head in the sand’ approach is not a valid option in today’s healthcare environment. A challenge is now laid to address the ethical responsibility of supporting bereaved nurses in a more constructive manner.
References


Matheson, D. (2013). *From great to good: How a leading New Zealand DHB lost its ability to focus on equity during a period of economic constraint.* Wellington, New Zealand: Wellington Massey University.


Appendices

Appendix 1: Research results table

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**Summary Table of Articles**

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- To explore the therapists' lived experience of personal bereavement  
- It's impact upon their practice. | 4 master & eight subordinate themes emerged:  
- Bereavement as a unique experience - range of affective responses (often contradictory) that continually change over time; impact upon sense of self, social identity, beliefs given varying degrees of emphasis  
- Re-learning the world - via personal growth and development of new sense of self; need to be heard and witnessed  
- Personal and professional synergies - need for personal and professional development essential for safe practice (to have worked through personal loss); importance of role of supervision which validated participants both personally and professionally  
- Impact upon therapeutic practice - personal experience enhances empathic understanding and connectedness with clients; use of self-disclosure only valid if solely for the benefit of the client |

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Methodology of data collection and analysis appropriate to obtain data to meet research aims  
Issue of bias addressed (researcher herself had experienced bereavement) via trying to balance the phenomenological attitude with researcher reflexivity - through process of self-reflection/questioning, writing of research journal and supervision  
Purposive sampling strategy used to obtain homogenous sample |

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|   | **Aims**  
|   | - To explore the support reported by parents on their return to the workplace following the death of their child by suicide  
|   | - To record the views |
|   | **Sample size** n=11 (six mothers, five fathers), ages 44-57. Children (deceased) aged between 15-27 years |
|   | **Sites** Variation of large and small organisations, |
|   | **Outcome Criteria** All experience valid |
|   | **Sample Size** n=145 – 67% women, 33% men, ages 18-65 |
|   | **Sites** Various organisations within Illinois |
|   | **Outcome Criteria** All experience valid |
|   | Confidentiality maintained  
|   | Study design appropriate  
|   | Data obtained relates to research question |
|   | However  
|   | Recruitment – individuals in social settings (supermarkets, bowling alleys) handed questionnaire and participation invited. Potential for bias/judgements made on who was given study information.  
|   | No evidence of consideration of ethical implications of study |
|   | Recommendation for future research  
|   | “Future studies should investigate the effects of stifled grief on both the employee’s mental health and on performance of different jobs, as the effects may vary depending on the nature of the work.”  
|   | Introduces concept of ‘stifled grief’ cf ‘disenfranchised grief’ |

---

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Study Design</strong> Qualitative, semi-structured, in-depth interviews</td>
</tr>
</tbody>
</table>
|   | **Aims**  
|   | - What was helpful  
|   | - From colleagues (acknowledgement; help; sensitivity; inclusion; acts of kindness; listening; taking part of workload; protecting)  
|   | - From management (paid leave as chosen; phased return to work/reduced duties; flexibility in hours; recognition of impact on work performance; keeping pressure off for first year; respect and being needed)  
|   | - Work a useful distraction; provide focus |
|   | - What was unhelpful  
|   | - From colleagues (insensitive comments; flippant/appropriate remarks or conversations re (other) suicide; trite |
|   | **Sample size** n=11 (six mothers, five fathers), ages 44-57. Children (deceased) aged between 15-27 years |
|   | **Sites** Variation of large and small organisations, |
|   | Qualitative methodology and design appropriate  
|   | Setting of data collection clear, appropriate Ethical standards for research maintained  
|   | Thematic data analysis consistent with methodology |
|   | N.B. Lead researcher herself a mother bereaved by suicide – problems of bias overcome by  
|   | - Invitation to 5 participants to review/comment on emerging themes  
<p>|   | Independent (k2) analysis of data undertaken |</p>
<table>
<thead>
<tr>
<th>Study Design</th>
<th>Sample size</th>
<th>Findings: 5 key themes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative, phenomenological, one-to-one semi-structured interviews</td>
<td>n=10 employees (8 female, 2 male)</td>
<td>Others perception of ‘closeness’ to the relative impacted upon support received</td>
</tr>
<tr>
<td>Aim</td>
<td>Sites</td>
<td>The line manager - A personal approach from good line manager can ‘make all the difference’ to the bereaved employee; employees ability to recall exact phraseology of manager months/years after the event; at times initial support evaporated once returned to work</td>
</tr>
<tr>
<td>To determine whether human resource policies support a compassionate community approach to bereavement</td>
<td>A variety of private and public sector settings, both large and small</td>
<td>Use of ‘policy’ documents – variability in interpretation; used in unintended ways</td>
</tr>
<tr>
<td>To investigate flexibility with which human resource policy is</td>
<td>Outcome Criteria</td>
<td>Understanding of the process of grief – fluctuating and long-term effects of grief; increasing inability to concentrate; positive benefits of attending work when grieving</td>
</tr>
<tr>
<td>Bereavement Care, 32(1), 4-</td>
<td>All employee perceptions and experience valid</td>
<td>Financial impact – paid leave typically 2-5</td>
</tr>
</tbody>
</table>

**However**
Limited transferability of research, as:
- Small sample size limited to small geographical location in Northern Ireland – cultural limitations
- Most participants had received grief counselling through a local support organisation which may have influenced the way in which they perceived and coped with their return to work –

**Conclusion**
Useful insight into topic provided however results cannot necessarily be extrapolated to reflect the experiences of employees in other settings. Study results add weight to need for further research (including that of managers, employers, organisations) in this area.

**Incl Criteria**
Bereaved by child suicide more than 18 months previously

**Self-employed**

**Statements; perceived avoidance**
- from management (lack of formal support; non-recogniton of difficulties; expectation to perform at previous levels/cope with challenging tasks; being confronted or feeling bullied)
- Formal support in the workplace - none offered help to find support; none felt they received the support they needed; some sought help but either found it unhelpful or didn’t follow-up
- What was needed - face-to-face contact with nominated person within organisation to assist with finding support; provision of guidance materials; support from professional appropriately qualified; talking to someone similarly bereaved
- Recommendations – survivor-informed training for managers/workers re responding to bereaved co-workers

**However**
Self-selected sample

**Northern Ireland**
<table>
<thead>
<tr>
<th>Study Design</th>
<th>Sample Size</th>
<th>Outcome Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenomenological study - interviews with open-ended questions</td>
<td>14 women aged 29-58</td>
<td>All personal experience of loss valid to inform study</td>
</tr>
<tr>
<td>Aims</td>
<td>Sites</td>
<td>Outcome Criteria</td>
</tr>
<tr>
<td>Not specifically identified — 2 aims is to explore the lived experience of those who have experienced perinatal death</td>
<td>All live in Great Lakes region, Canada</td>
<td>All personal experience of loss valid to inform study</td>
</tr>
</tbody>
</table>

**Incl Criteria**
- Experience of perinatal loss (miscarriage or termination, stillbirth, death of infant shortly after birth)

**Conclusion**
Useful insight into topic provided however results cannot necessarily be extrapolated to reflect the experiences of employees in other settings. Study results (differing experiences of participants) add weight to need for further research (including that of managers) in this area.

**Limitation**
Clear acknowledgement of researcher bias (experienced death of only child at 2 days old) – supervision by psychologist and involvement in reflective writing workshop assisted in maintaining objectivity

**Incl**
- Age range of participants
- Data relating to type of bereavement, relationship of the deceased to the employee
- Previous experience of employee with bereavement

**Conclusion**
Minimal evidence to inform research, but can add weight to other research.

**Study Design**

**Sample Size**

**Outcome Criteria**

**Inclusion Criteria**
- Employees affected by bereavement in past 5 years
- Financial difficulties of unpaid leave major factor in taking further time off;
- Expectation of some employees to get further paid compassionate leave; personal financial strain when deceased estate in probate
- Evidence of some organisations understanding and handling employee bereavement well. However, others did not realise the negative impact associated with poor management (increased sick leave, absences, low morale)

**Conclusion**

**Limitation**

**Incl**
<table>
<thead>
<tr>
<th></th>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
<th>Country</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Sample Size Notes</th>
<th>Outcome Criteria</th>
<th>Incl Criteria</th>
<th>Limitation</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Iype, N.</td>
<td>2010</td>
<td>The experience of grief: An art therapist’s exploration.</td>
<td>Canada</td>
<td>Personal, qualitative, heuristic, and arts-based enquiry</td>
<td>1 participant – the researcher</td>
<td>N/A</td>
<td>Researcher’s personal experience of loss</td>
<td>All experience of this one participant</td>
<td>This heuristic study focuses on the researcher’s experience of grief, as she witnesses the physiological, psychological and emotional decline of her father who is dying of an untreatable, fatal illness. Her experience of grief does have significant impact upon her work as an art therapist.</td>
<td>This study cannot be used to inform my literature review, as it discusses the nature and impact of grief/loss as it relates to the anticipated death of the researcher’s father. Therefore it does not fulfill the criteria of experience of bereavement following the death of a loved one.</td>
</tr>
<tr>
<td>10</td>
<td>Maxim, L. S. &amp; Mackavey, M. G.</td>
<td>2005</td>
<td>Best practices regarding grief and the workplace.</td>
<td>United States</td>
<td>Surveys 2x: 1) Bereaved workers; 2) Employers re policy</td>
<td>Survey 1: n=12</td>
<td>Survey 2: n=34</td>
<td></td>
<td></td>
<td>Methodology appropriate Sampling self-selected Minimal issues of bias due to design of study (surveys)</td>
<td>Incl</td>
</tr>
</tbody>
</table>

**However:** Ethical considerations not discussed Sample size of survey 1 was inadequate to generalise results Data from survey 2 (amount of paid bereavement leave) not directly transferable to NZ, as the minimum of this is mandated by law (see section 69 (2)(a) of the Holidays Act 2003) **Note:** Maxim quotes authors who say that women are faster to recover from normal grief than men (opposite of...
<table>
<thead>
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</thead>
<tbody>
<tr>
<td><strong>Survey</strong></td>
<td><strong>Sample Size</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Aims</strong> To ascertain current bereavement policies and practices within Irish organisations</td>
<td><strong>n=34 organisations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Incl Criteria</strong> Nil stated</td>
<td><strong>Sites</strong> Variation of small, large, private, public and local government – all in Ireland</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Criteria</strong> Bereavement leave days</td>
<td><strong>Current Policies</strong> Experience of employee bereavement was universal amongst all organisations within previous 12 months. BUT STILL 88% (n=30) had no formalised bereavement policy to guide staff</td>
<td></td>
</tr>
<tr>
<td><strong>Compassionate Leave</strong> 91% (n=31) made some kind of provision for leave (commonly 3-5 paid days) - 38% (n=13) = &gt; 5days, 50% (17) = 3 days, 1 = 2 days.</td>
<td><strong>Organisations understanding of impact of bereavement on employees</strong> 94% - employee’s work performance was, or could be affected by bereavement</td>
<td></td>
</tr>
<tr>
<td><strong>Support for employees</strong> Evidence of good practice, however also gaps. Short-term support immediately following death good, but long-term support</td>
<td><strong>Conclusion</strong> Small sample sizes, but useful to promote thinking around my research</td>
<td></td>
</tr>
<tr>
<td><strong>Incl</strong></td>
<td>Appropriate design of study (survey), data collected appropriate to inform the research aims. Self-selecting sampling, reasonable sample size Analysis – data remains raw – themes left to reader to create</td>
<td></td>
</tr>
<tr>
<td><strong>However:</strong> Issues of ethics not discussed Possible issues of bias, as study sponsored/undertaken by Irish Hospice Foundation (although I don’t see this as having enough impact to affect the validity of the study)</td>
<td><strong>Note:</strong> In Ireland and the European Union – no mandates from central governments regarding bereavement/compassionate leave (paid or otherwise) – entirely at discretion of employer</td>
<td></td>
</tr>
</tbody>
</table>
| | **Discussion** “Managers generally wanted to do the
<table>
<thead>
<tr>
<th>Page</th>
<th>Citation</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Sample Selection</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Naidoo, V. &amp; Delport, R. (2009). The need for bereavement support programmes in the workplace. <em>Social Work, 45</em>(4 SPECIAL ISSUE). 461-476+xii. South Africa</td>
<td>Study Design: Quantitative questionnaire&lt;br&gt;Aims: To investigate the need for an employee bereavement programme at Umgeni Hospital&lt;br&gt;Incl Criteria: All staff employed at this hospital</td>
<td>Sample Size: 70 employees (of 422)&lt;br&gt;Sites: Umgeni Hospital, South Africa&lt;br&gt;Outcome Criteria: All experience valid</td>
<td>An overwhelming percentage of respondents received support following their bereavement. However, despite this (94%) felt that they would have benefited from a bereavement programme facilitated in their workplace.&lt;br&gt;A support group was identified as the preferred format for this bereavement programme</td>
<td>Sampling – systematic probability, randomly chosen (each fifth employee) up to sample of 70 (16%).&lt;br&gt;Data Analysis – using SPPS statistical package&lt;br&gt;Ethical considerations of informed voluntary consent, privacy, confidentiality and anonymity addressed within the small population&lt;br&gt;Useful evidence for need for employer-provided bereavement support programme</td>
</tr>
<tr>
<td>13</td>
<td>Ripps, P. (1992). <em>The psychological relationship between death loss and the experience of the bereaved employee in the workplace.</em> (Doctoral dissertation,</td>
<td>Study Design: Quantitative survey with some free text elements&lt;br&gt;Aims: To explore what the business community offers in terms of bereavement support&lt;br&gt;To explore the experiences of</td>
<td>Sample Size: 418 participants&lt;br&gt;Sites: One large Southwestern community&lt;br&gt;Outcome Criteria: All experience valid and useful</td>
<td>76% - had their loss acknowledged from their workplace, via a card, flowers or attendance at the funeral – however 86% by work colleagues not their employer.&lt;br&gt;51% - use of alcohol following the death, with 13% reporting an increase&lt;br&gt;15% - increase in use of prescription drugs post bereavement, however type of medication and reason for use not collected.&lt;br&gt;68% - work performance dropped in the first month; 44% in first 3 months; 33% still felt work performance was affected up to 6 months. This results in a significant cost to the</td>
<td>Sampling – random selection of 2000 potential participants via mailing lists associated with local mortuaries, and professionals who attended the bereavement conference. Snowballing was then used if the initial participant was either unwilling or unsuitable for participation.&lt;br&gt;Ethical considerations – anonymity maintained. Ethics approval from academic institution.&lt;br&gt;Analysis – appropriate to methodology</td>
</tr>
<tr>
<td>Title</td>
<td>Study Design</td>
<td>Sample Size</td>
<td>Impact of the loss</td>
<td>Limitations</td>
<td></td>
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<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Trimble, B. (2010). An exploratory study of grief in the workplace:</td>
<td>Self-report questionnaire utilising open-ended and closed questions</td>
<td>Sample size of 27-18 women, 9 men (18-65 years)</td>
<td>• Financial, social, domestic and work impacts all inter-related, impact in one area often resulted in issue in another (need to reduce hours; increased childcare expenses); reduced social life following loss secondary to death of primary social contact; reliance on medication/alcohol to assist with sleep/anxiety; perception of having to ‘hide’ grief (from dependents); sense of delayed bereavement; new responsibilities (adult child now caring for surviving, now lone parent); stress of not functioning properly; inability to concentrate (62%); increased insomnia, fatigue (43%); routine became ‘haphazard’;</td>
<td>Sample not representative of the organisation let alone other practice settings. However, still useful as findings are fully reflective of these individual’s experiences. All respondents involved in sedentary roles, where fatigue is less likely to impact upon safety issues, and risk to self and others is potentially less than in other.</td>
<td></td>
</tr>
<tr>
<td>What do employers need to know? (Hons thesis, Dublin Business School,</td>
<td>Aims To explore the experience of those who returned to their workplace following the death of someone close to them</td>
<td>Site: One national organisation (type not specified). All respondents involved in sedentary roles</td>
<td>Participant selection via convenience and snowballing Ethical considerations addressed. Participants and data kept confidential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dublin, Ireland). Retrieved from <a href="http://resource.dbs.ie/bitstream/">http://resource.dbs.ie/bitstream/</a></td>
<td><strong>Incl Criteria</strong> Experience of a death loss whilst employed</td>
<td><strong>Outcome Criteria</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

United States

employees after a death loss
- To examine the cost to the employers associated with an employee bereavement

**Incl Criteria**
Experience of a death loss whilst employed

**Outcome Criteria**

- Employer
  - Most hurtful experiences re colleagues and supervisors avoiding the bereaved, and comments to ‘get on with life’ or to ‘snap out of it’
  - 39% took time off additional to their immediate bereavement leave
  - Need for team leader and co-worker bereavement training, helpful and unhelpful practices
  - Need for organisational bereavement policy allowing for flexibility in timing of leave (N.B. many policies only allow leave to be taken at the time of the loss).
  - Team leader make personal contact with bereaved employee prior to returning to work to establish what the employee’s individual needs are
  - Flexibility to take short breaks from work, reduce work hours during transition period
  - Recognition of anniversary dates
  - Easily accessed resources (counselling)

**Limitation**
Sample collected from data bases of those already affiliated with bereavement, therefore results may not be generalizable.
| handle/10788/74/ba_trimble_breda_2010.pdf?sequence=1 | All suffered personal bereavement and all returned to workplace following bereavement | Not articulated | struggled to make decisions re: menial tasks; overwhelmed by work demands; expectation of managers to cope added greatly to stress; inability to stop crying at work, causing acute embarrassment. • return to work – importance of acknowledged loss; enquiry re how bereaved is coping; eliminate pressure to perform; need for education of managers to proactively offer bereavement services • 93% - need for longer than five days paid leave – many took increased sick leave (2 days – 6 weeks) • 41% used counselling/bereavement group | occupational settings |
Appendix 3: Nurse manager survey tool

<table>
<thead>
<tr>
<th>When nurses grieve - Charge Nurse questionnaire - Fiona Rowan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hi, my name is Fiona Rowan. As part of completing a Master of Nursing degree through the Eastern Institute of Technology (EIT), I am conducting a thesis research project that seeks to answer the question “how are nurses supported to work following a personal bereavement experience?” In this study, the experience of nurses who have worked during the grief recovery period following a personal bereavement will be examined in the context of existing organisational bereavement policy and practice in New Zealand. Particular emphasis will be given to identifying barriers and enablers to providing support for registered nurses, beneficial and detrimental strategies and policy, and making recommendations for future practice.</td>
</tr>
<tr>
<td>The study has two key aims</td>
</tr>
<tr>
<td>• To find out the extent of existing policy and practice regarding bereavement support for Registered Nurses working in Staff Nurse roles in New Zealand secondary and tertiary health care sectors</td>
</tr>
<tr>
<td>• To ascertain the experience of Registered Nurses working in Staff Nurse roles in the same practice settings, regarding their work experience following a personal bereavement</td>
</tr>
<tr>
<td>How you can help</td>
</tr>
<tr>
<td>I am seeking Charge Nurses and Nurse Managers who work in secondary or tertiary health care in New Zealand, who have immediate team leader responsibility for Registered Nurses working in Staff Nurse roles, to participate in an anonymous on-line survey. Involvement in this research will allow Charge Nurses and Nurse Managers to ‘have a voice’ regarding their experience of supporting bereaved Registered Nurses, both during the nurse’s bereavement leave time, and upon their return to work.</td>
</tr>
<tr>
<td>The survey</td>
</tr>
<tr>
<td>• Takes approximately 10 minutes to complete</td>
</tr>
<tr>
<td>• Involves you answering multi-choice questions and indicating the extent to which you agree or disagree with statements</td>
</tr>
<tr>
<td>• Provides ‘free space’ for you to add comments that more fully explain your experience related to the research question</td>
</tr>
<tr>
<td>• You can choose to not answer any questions that you are not comfortable with</td>
</tr>
<tr>
<td>• Your participation is entirely voluntary and submission of the survey implies consent to participate in it</td>
</tr>
<tr>
<td>• Your participation will not jeopardise your employment in any way</td>
</tr>
<tr>
<td>Ethical considerations</td>
</tr>
<tr>
<td>• Ethics approval for this study has been obtained from the Research Ethics and Approval Committee of the Eastern Institute of Technology</td>
</tr>
<tr>
<td>• Approval for you to participate has been obtained from your District Health Board (DHB).</td>
</tr>
<tr>
<td>• Both you, and the DHB in which you work, are assured of anonymity</td>
</tr>
<tr>
<td>• All responses will be confidential and will not be able to be linked to individual participants</td>
</tr>
<tr>
<td>• Information obtained through this research will not be used for any purpose other than the identified research study</td>
</tr>
<tr>
<td>If you have any questions regarding this research, please contact</td>
</tr>
<tr>
<td>Fiona Rowan, student, Master of Nursing, Faculty of Health Science, Eastern Institute of Technology, email: <a href="mailto:fiona.rowan@midcentraldhb.govt.nz">fiona.rowan@midcentraldhb.govt.nz</a></td>
</tr>
<tr>
<td>Dr Clare Harvey, Associate Professor of Nursing, Faculty of Health Science, Eastern Institute of Technology email: <a href="mailto:CHarvey@eit.ac.nz">CHarvey@eit.ac.nz</a> (Principal Supervisor)</td>
</tr>
<tr>
<td>Please complete or respond to the following statements and questions regarding your work with the registered nurses working in staff nurse roles on your team.</td>
</tr>
<tr>
<td>Please note: For the purposes of this study, ‘personal bereavement’ is defined as the death of a loved one (family member, friend or colleague) only. This study does not include information regarding bereavement following divorce, illness, loss of role, pet etc.</td>
</tr>
<tr>
<td>Please answer the following questions about you and your work</td>
</tr>
</tbody>
</table>
When nurses grieve - Charge Nurse questionnaire - Fiona Rowan

1. Please indicate your gender
   - Male
   - Female

2. Please indicate your age
   - 20-29 years
   - 30-39 years
   - 40-49 years
   - 50-59 years
   - Over 60 years

3. How many years of nursing experience do you have?
   - 0-4 years
   - 5-9 years
   - 10-19 years
   - 20-29 years
   - 30 years or more

4. How many years of nursing management/leadership experience do you have?
   - 0-1 year
   - 2-4 years
   - 5-9 years
   - 10-15 years
   - 16 years or more
When nurses grieve - Charge Nurse questionnaire - Fiona Rowan

5. What type of clinical area do you currently have managerial responsibility for? (Please choose the best answer)

- Assessment and Rehabilitation/Elder Health
- Child Health (including Neonatology)
- District Nursing
- Emergency and Trauma
- Intensive Care/Cardiac Care
- Medical
- Mental Health
- Obstetrics/Maternity
- Oncology
- Perioperative Care
- Palliative Care
- Surgical
- Other (please specify)

6. How many years have you been in your current position?

- 0-1 year
- 2-4 years
- 5-9 years
- 10-15 years
- 16 years or more
When nurses grieve - Charge Nurse questionnaire - Fiona Rowan

7. How many registered nurses working in staff nurse roles, do you have responsibility for managing?

8. In the past year, how many of these nurses have experienced a personal bereavement?
Reminder: For the purposes of this study, 'personal bereavement' is defined as the death of a loved one (family member, friend or colleague) only.

Please complete or respond to the following statements and questions about bereavement policy within your organisation. Please remember that for the purposes of this study 'personal bereavement' is defined as the loss of a loved one (family member, friend or colleague).

9. My organisation has written policy (or policies) that assist me to support registered nurses to work following a personal bereavement

- Yes
- No (if 'no', please go to question 11)
- I don't know (if 'I don't know', please go to question 11)
10. If you answered 'yes' to question 9, what is the content of this policy/ these policies? (Tick as many as is applicable)

☐ Provides guidance regarding accessing paid bereavement leave

☐ Provides guidance regarding amount of paid bereavement leave

☐ Provides guidance regarding accessing unpaid bereavement leave

☐ Provides guidance regarding amount of unpaid bereavement leave

☐ Provides guidance regarding how to talk with the bereaved registered nurse

☐ Provides practical suggestions of how to support the bereaved registered nurse

☐ Provides guidance regarding how to support other team members/colleagues of the bereaved registered nurse

☐ Provides guidance regarding accessing professional counselling for the bereaved registered nurse

☐ Provides a list of resources available to support the bereaved registered nurse

☐ I don’t know the content of this policy

☐ Other (please specify)

---

Please complete or respond to the following statements and questions about your experience of supporting registered nurses who have experienced a personal bereavement

11. In the past five years, in your role as team leader, have you been involved with a registered nurse working in a staff nurse role, taking bereavement leave?

☐ Yes

☐ No (If 'no', please go to question 15)
When nurses grieve - Charge Nurse questionnaire - Fiona Rowan

12. If you answered 'yes' to question 11, what options were made available?

- [ ] Flexibility with regard to the length of approved paid leave
- [ ] Flexibility with regard to the length of approved unpaid leave
- [ ] Other (please specify)

13. Prior to returning to work, was the registered nurse assessed as being safe to work?

- [ ] Yes
- [ ] No

14. If you answered 'yes' to question 13, who undertook this assessment, and what factors were considered as part of this assessment? If you answered 'no' to question 13, what factors influenced this?

15. In the past five years, in your role as team leader, have you been involved with supporting a registered nurse returning to work following a personal bereavement experience?

- [ ] Yes
- [ ] No (If 'no', please go to question 21)
When nurses grieve - Charge Nurse questionnaire - Fiona Rowan

16. If you answered 'yes' to question 15, what options were made available?

☐ Flexibility with regard to work hours
☐ Flexibility with regard to work load
☐ Other (please specify)

Please indicate whether you strongly agree, agree, disagree or strongly disagree with each of the following statements

17. I offer support to registered nurses who have experienced a personal bereavement in a way that is culturally appropriate to the bereaved nurse

<table>
<thead>
<tr>
<th>strongly agree</th>
<th>agree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
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<tr>
<td>()</td>
<td>()</td>
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<td>()</td>
</tr>
</tbody>
</table>

Comment

18. I always advise the bereaved registered nurse about the professional counselling/support available to him/her

<table>
<thead>
<tr>
<th>strongly agree</th>
<th>agree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
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Comment
19. I do not feel confident providing support to registered nurses who have experienced personal bereavement

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<th>strongly agree</th>
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20. I feel that I manage the support of bereaved registered nurses well

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21. The following professional crisis intervention/counselling/support is offered to bereaved registered nurses in my organisation. (Tick as many as are applicable)

- [ ] Employee Assistance Programme
- [ ] Clinical supervision
- [ ] Hospital Chaplain
- [ ] Other (please specify)

22. A range of written resources regarding bereavement and grieving are available within my organisation that I can offer to bereaved registered nurses

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23. I have received enough training/education/professional development to help me support bereaved registered nurses in my team

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Please indicate how strongly you agree or disagree

Comment

24. Do you have any other comments you would like to make regarding the bereavement care you provide, or would like to provide, to the registered nurses on your team?

Comment

25. I give my consent for this information to be submitted

Yes
No

Thank you for the time you have taken to answer these questions. The information you have provided is invaluable in assisting to paint a picture that shows how bereaved nurses are currently being supported to work in New Zealand.
Appendix 4: Registered nurse survey tool

When nurses grieve - Registered Nurse survey - Fiona Rowan research

Hi, my name is Fiona Rowan. As part of completing a Master of Nursing degree through the Eastern Institute of Technology (EIT), I am conducting a thesis research project that seeks to answer the question "how are nurses supported to work following a personal bereavement experience?". In this study, the experience of nurses who have worked during the grief recovery period following a personal bereavement will be examined in the context of existing organisational bereavement policy and practice in New Zealand. Particular emphasis will be given to identifying both beneficial and detrimental strategies and policy, as perceived by bereaved Registered Nurses, and making recommendations for future practice.

The study has two key aims
- To ascertain the experience of Registered Nurses working in the role of Staff Nurse in the secondary and tertiary health care sectors in New Zealand, regarding their work experience following personal bereavement
- To find out the extent of existing policy and practice regarding bereavement support for Registered Nurses working in the same practice settings

How you can help
I am seeking nurses who have experienced a personal bereavement to participate in an anonymous on-line survey. For the purposes of this study, 'personal bereavement' is defined as the death of a loved one (family member, friend or colleague) only. Involvement in this research will allow nurses who have experienced personal bereavement to 'have a voice' regarding their experience of working through the initial bereavement recovery period. In order to participate, you must
- be a Registered Nurse who was working in a Staff Nurse role within a New Zealand secondary or tertiary health care organisation at the time of your bereavement
- have experienced the death of a loved one (family member, friend or colleague) more than 18 months but less than five years ago.

If your bereavement was less than 18 months ago, or more than five years ago, you are asked not to participate in this study.

The survey
- Takes approximately 15-20 minutes to complete
- Involves you answering multi-choice questions and indicating the extent to which you agree or disagree with statements
- Provides ‘free space’ for you to add comments that more fully explain your experience related to the research question
- You can choose to not answer any questions that you are not comfortable with
- Your participation is entirely voluntary and submission of the survey implies consent to participate in it
- Your participation will not jeopardise your employment in any way

It is recognised that this topic is extremely personal and may potentially cause some nurses emotional distress. Only nurses who feel comfortable to participate are encouraged to do so. Should this study re-awaken painful memories for you, you are encouraged to seek support from family, colleagues or professional advisers.

Ethical considerations
- Ethics approval for this study has been obtained from the Research Ethics and Approval Committee of the Eastern Institute of Technology
- Both you, and the District Health Board in which you work, are assured of anonymity
- All responses will be confidential and will not be able to be linked to individual participants
- Information obtained through this research will not be used for any purpose other than the identified research study
- Any information that is offered regarding patients, work or employment that may indicate serious misconduct will not be used in any report, publication or conference proceedings.

If you have any questions regarding this research, please contact:
Fiona Rowan, student, Master of Nursing, Faculty of Health Science, Eastern Institute of Technology, email: fiona.rowan@midcentraldhb.govt.nz
Dr Clare Harvey, Associate Professor of Nursing, Faculty of Health Science, Eastern Institute of Technology, email: CHarvey@eit.ac.nz (Principal Supervisor)
When nurses grieve - Registered Nurse survey - Fiona Rowan research

Please complete the following statements about you and your work

1. I am
   - Male
   - Female

2. I am ___________ old
   - 20-29 years
   - 30-39 years
   - 40-49 years
   - 50-59 years
   - Over 60 years

3. The race/ethnicity that I most identify with is ________________
   - New Zealand European/Pakeha
   - Other European
   - New Zealand Maori
   - Asian
   - Pacific Islander
   - Multiple ethnicities/other (please specify)

Just a reminder, for the purposes of this study, ‘personal bereavement’ is defined as the death of a loved one (family member, friend or colleague) only. This study does not include information regarding bereavement following divorce, illness, loss of role, death of a pet etc.

If you have experienced the death of more than one loved one greater than eighteen months but less than five years ago, please complete a separate questionnaire for each bereavement event.
4. I have _______ of nursing experience

- 0-4 years
- 5-9 years
- 10-19 years
- 20-29 years
- 30 years or more

5. The clinical area I was working in at the time of my bereavement, is best described as

- Assessment and Rehabilitation/Elder Health
- Child Health (including Neonatology)
- District Nursing
- Emergency and Trauma
- Intensive Care/Cardiac Care
- Medical
- Mental Health
- Obstetrics/Maternity
- Oncology
- Perioperative Care
- Palliative Care
- Surgical
- Other (please specify)
6. At the time of my bereavement, I had been working in this department for

☐ 0-1 year
☐ 2-4 years
☐ 5-9 years
☐ 10-15 years
☐ 16 years or more

Please complete or respond to the following statements about your bereavement

7. It has been _______________ since my loved one died

☐ less than 18 months
☐ more than 18 months, but less than two years
☐ more than two years, but less than three years
☐ more than three years, but less than four years
☐ more than four years, but less than five years
☐ more than five years

8. My loved one was _____________ when he/she died

☐ 0-9 years old
☐ 10-19 years old
☐ 20-44 years old
☐ 45-69 years old
☐ over 70 years old
9. My loved one who died was my
- grandparent
- parent
- spouse
- sibling
- child
- extended family member
- friend
- colleague
- other (please specify)

10. My loved one’s death was
- anticipated, after a period of illness lasting less than one month
- anticipated, after a period of illness lasting more than one month but less than six months
- anticipated, after a period of illness lasting more than six months
- unexpected, as a result of natural causes
- unexpected, as a result of an accident/injury
- unexpected, as the result of violence
- unexpected, as the result of suicide
- unexpected, as the result of a natural disaster (e.g. earthquake, cyclone)

11. I would describe my relationship with my loved one who died as
- extremely close
- close
- neither close nor distant
- distant
- hostile
When nurses grieve - Registered Nurse survey - Fiona Rowan research

Please complete or respond to the following statements about the support received from your manager immediately following your bereavement

12. Following my bereavement but before my return to work, my manager communicated well with me

Please explain

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13. My manager did not understand my particular needs to support myself and my family through the grieving process

Please explain

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<td>14. I was treated with respect by my manager</td>
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<td>15. My manager was compassionate towards me</td>
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<td>16. My manager assisted me to work out my leave entitlements</td>
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Comment

When nurses grieve - Registered Nurse survey - Fiona Rowan research

Page 7
17. My organisation did not offer me assistance to access professional support services
Please explain

Please indicate how strongly you agree or disagree

Also feel free to comment on any professional support services used and how helpful they were

18. My organisation offered me written resources about bereavement and grieving to help me understand what I was experiencing
Please explain

Please indicate how strongly you agree or disagree

Also feel free to comment on any written resources used and how helpful they were

Please complete or respond to the following statements about your return to work experience following your bereavement

19. My organisation has a written policy regarding employees working following a personal bereavement

- Yes
- No
- I don’t know
20. Prior to returning to work, my manager and I discussed whether or not I was safe to recommence working
Please explain what factors (if any) were considered as part of this discussion

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21. My manager was supportive of me when I returned to work
Please explain

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22. I felt that the concerns I had about returning to work, were not listened to by my manager

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23. When I returned to work, I was offered flexible work options if I needed them

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Comment
24. When I returned to work, I was offered a reduced workload if I needed it

Please indicate how strongly you agree or disagree

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25. When I returned to work, my colleagues were supportive of me

Please indicate how strongly you agree or disagree

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Please complete or respond to the following statements about how you were feeling when you returned to work

26. When I returned to work, I felt I was safe to work

Please explain

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27. When I returned to work, I felt my critical analysis skills were intact

Please explain

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28. When I returned to work, I was experiencing the following physical grief symptoms
Please tick as many as you were feeling

- insomnia
- fatigue
- listlessness
- frequent tearful episodes
- loss of appetite
- headaches
- pain
- difficulty breathing
- shaking/trembling
- Other (please specify)
29. When I returned to work, I was experiencing the following psychological grief symptoms

Please tick as many as you were feeling

- inability to stop thinking about my loved one who died
- disinterest in people around me
- things happening around me that I didn't notice
- inability to get motivated about my work
- difficulty concentrating
- difficulty making decisions
- poor memory/recall of information
- impaired critical analysis skills
- being easily distracted
- other (please specify)
30. When I returned to work, I was experiencing the following emotional grief symptoms
Please tick as many as you were feeling

☐ anger
☐ guilt
☐ fear
☐ anxiety/worry
☐ loneliness
☐ sadness/yearning for what has been lost
☐ numbness/feeling empty inside
☐ confusion
☐ inability to see a fulfilling future ahead
☐ other (please specify)

31. When I returned to work, I was experiencing the following spiritual grief symptoms
Please tick as many as you were feeling

☐ inability to make sense of life
☐ searching for meaning in life
☐ separation from spiritual support
☐ anger at spiritual beings
☐ other (please specify)
When nurses grieve - Registered Nurse survey - Fiona Rowan research

32. My bereavement experience impacted upon my ability to work in the following ways
Please explain

33. After returning to work, I took sick leave days, when I felt I needed to

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34. After returning to work, the following situation/s made me think that I wasn’t safe to work after all
Please explain

Please provide any suggestions you may have for improving how nurses are supported to work following a personal bereavement experience
35. Based upon my experience of working after a personal bereavement, I would like to see managers/employers/organisations supporting nurses who have experienced the death of a loved one in the following ways

36. Based upon my experience of working after a personal bereavement, I would like to see managers/employers/organisations avoiding the following practices, when supporting nurses who have experienced the death of a loved one

37. I would like to make these additional comments
38. I give my consent for this information to be submitted

- Yes
- No

Thank you for the time you have taken to answer these questions. The information you have provided is invaluable in assisting to paint a picture that shows how bereaved nurses are currently being supported to work in New Zealand.

As I am interested in obtaining a national perspective of bereavement support for Registered Nurses, please forward this survey link on to other New Zealand nurses whom you think may be interested in participating.
Appendix 5: Faculty Academic Committee approval

24 June 2014

Fiona Rowan

Dear Fiona,

The Faculty Academic Committee met on Friday 20 June and approved your research proposal topic “When nurses grieve: how well are we caring for the carers?”

Please note that this approval is approval to proceed with the research, and is not ethical approval. You must obtain ethical approval from EIT’s Research and Approvals Committee before commencing data collection for your research. This committee has deadline dates for receiving applications for approval, which is two weeks before the meeting date for each month. The next meeting date for this committee is 25 July 2014, therefore the deadline date for applications is 11 July 2014.

If you have any questions in relation to this, please contact Dr Elaine Papps, M9.490 Masterate Research Course Coordinator.

Yours sincerely,

Jennifer Roberts
Assistant Head of School, Nursing
For the Faculty Academic Committee
Faculty of Education, Humanities & Health Science

cc: Associate Professor Clare Harvey, Alasdair Williamson
Appendix 6: Research Ethics approval

Reference Number 31/14

30 June 2014

Fiona Rowan
Masterate Nursing Student
C/- School of Nursing
EIT

Dear Fiona

I am pleased to inform you that your research project “When nurses grieve? How well are we caring for the carers” was approved by the Research Ethics & Approvals Committee at their meeting held on 27 June 2014. The Reviewers also commended you for providing a well written and clear proposal.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number on all correspondence to the Committee.

The Committee wishes you well for the project.

Yours sincerely

Jeanette Fifield
Secretary – Research Ethics & Approvals Committee

cc: Associate Professor Harvey, Alasdair Williamson
Dear Fiona,

**Project: When Nurses Grieve: How well are we caring for the carers?**

Thank you for your informative research proposal and the accompanying information. There is nothing further to add except to comment that Māori are as diverse a group of people as many groups and while some will readily identify as Māori, they may have been raised in a nuclear focussed family and find Māori practices foreign. On the other hand, some Māori participants steeped in Māori cultural practises, may provide responses that are in keeping with their cultural practises or may answer the questions in a not dissimilar way to the first group.

More importantly there is no negative impact likely on Māori as a result of conducting this research.

A copy of this letter was presented to the kaumātua (elders) group at [insert location] on Thursday 7 August for their information and comment. They supported your research and wish you well in completing it. A copy of your research findings will be appreciated.

With kind regards

Yours sincerely

[Name]
Manager Māori Health Services
And on behalf of the kaumātua group
Appendix 8: District Health Board approval A

Locality Assessment Sign Off for Approval of Research/Clinical Trials

Full project title: When nurses grieve: How well are we caring for the carers?
Short project title: 

1. Declaration by Principal Investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the potential ethical, resource and cultural issues involved in this research and believe that I have adequately addressed them for this locality.

Name of Principal Investigator (please print): Fiona Rowan
Signature of Principal Investigator: 
Date: 15/7/14

2. Declaration by Clinical Leader of Service/Department in which the Principal Investigator is located

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for this locality to be included in the ethics committee application.

Name (please print): 
Signature: 
Institution: 
Date: 15/7/14
Designation: Director of Nursing

- Where the Clinical Leader is also one of the investigators, the Clinical Leader declaration must be signed by the Clinical Executive Director.

3. If the application is for a student project, the supervisor should sign the declaration.

I have read the application, and it is appropriate for this research to be conducted under my supervision. I give my consent for this locality to be included in the ethics committee application.

20/11/2012
4. **Declaration by relevant Operations Director**

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for this locality to be included in the ethics committee application.

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<th>Name (please print):</th>
<th>Dr Clare Harvey</th>
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<td>Signature:</td>
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<th>Institution: Eastern Institute of Technology</th>
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<tr>
<th>Designation: Associate Professor, School of Nursing</th>
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**Clinical Board Acknowledgement of Registration**

Signed: [Redacted]  
Designation: [Redacted]

Copy to be retained by Chief Medical Officer's office and details entered onto Register.

To be completed by the Principal Researcher and Operations Director. The Operations Director is to forward a copy of the form to the Clinical Board, vol. [Redacted]. All relevant supporting documentation is to be included.

---

20/11/2012  
Doc. No. [Redacted]  
Page 2/2
29 August 2014

Dear Fiona,

Thank you for the information you supplied to Ko Awatea Research Office regarding your research proposal:

Research Registration Number: [redacted]
Ethics Reference Number: [redacted]
Research Project Title: When nurses grieve: How well are we caring for the carers?

I am pleased to inform you that Counties Manukau DHB Research Committee and Director of Hospital Services have approved this research with you as the Co-ordinating Investigator. Your study is approved until 31/05/2015.

Amendments:
• All amendments to your study must be submitted to the Research Office for review.
• Any substantial amendment (as defined in the Standard Operating Procedures for HDECs, May 2012) must also be submitted to the Ethics Committee for approval.

All external reporting requirements must be adhered to.

Please note that failure to submit amendments and external reports may result in the withdrawal of Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely

[Name]
Health Intelligence and Informatics Lead
Under delegated authority from Research Committee and Director of Hospital Services
Appendix 10: District Health Board approval C

24 September 2014

Fiona Rowan

Dear Fiona

RE: Research Application - Reference

Thank you for your application to conduct research within the

The Research Office has had the opportunity to review your study and has given approval for your
research project to be conducted within

This Institutional Approval is dependant on the Research Office having up-to-date information and
documentation relating to your research and being kept informed of any changes to your study.

Please send the survey link to [redacted] who will
distribute this on behalf of the Chief Nursing Officer.

It is your responsibility to ensure you have kept Ethical Committees (as required) and the Research
Office up to date and have the appropriate approvals. Approval may be withdrawn for your
study if you do not keep the Research Office informed of the following:

- Any amendment to study documentation
- Study completion, suspension of cancellation

Conclusion of your Research

At the conclusion of your research you will be required to provide a written report of your research
findings to the [redacted] Research Office.

Please find enclosed a signed copy of your application. Should you have any queries during your
research, please do not hesitate to contact me during normal working hours.

Regards

[redacted]

[redacted]

On behalf of the
[redacted] Research Office

[redacted] New Zealand