IMPLEMENTATION OF A MENTORSHIP PROGRAM TO SUPPORT AND EDUCATE NURSES ON PERINATAL LOSS

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Dedication

I dedicate this important work to my maternal grandmother, my Bibi. She played a significant part in my childhood, my adolescence and my early adult years. She was and always will be my biggest role model. Because of her, I am a nurturer. Through her, I have learned what unconditional love means. During the last few months and days of her life, I spent a considerable amount of time being present, providing comfort and listening to her wishes. She taught my family and me the importance of being physically, emotionally and spiritually present, at the end of life and as an individual passes on to the spirit world. I continue to exhibit these characteristics in my nursing practice, especially as I provide care for bereaved families experiencing a perinatal loss. Thank you, Bibi. You are forever a part of all that I am and all that I will ever strive to become.

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Abstract

Perinatal loss, the experience of losing a fetus or neonate, is extremely difficult for the family and the primary bereavement care provider, the perinatal nurse. Empirical evidence suggests that optimizing the care experience for the bereaved family and supporting the care provider is crucial for cultivating positive experiences for these two populations. Notably, perinatal nurses who are new to perinatal bereavement care and/or palliative care lack the support and education for providing care to bereaved families, which has a detrimental effect on the family's care experience and the morale of nurses. As a result, nursing mentorship, specifically, a perinatal loss mentorship program, would be valuable for fostering positive experiences for perinatal nurses and the bereaved families, alike. This culminating project explores 1) the topics of mentoring, communication, emotional stressors and coping mechanisms, reflective practice, collaborative learning and decision making, and didactic and experiential learning, in a review of the literature and empirical evidence; and 2) the components and structure of a perinatal loss mentorship program. The program and findings could be generalized to other specialties as it cultivates: 1) holistic and individualized family-centered perinatal bereavement care, and 2) a culture of mentoring, communication, and collaboration among perinatal nurses. This culminating project and the mentorship program has nursing implications that: 1) foster moral resilience, 2) improve interprofessional collaboration, 3) promote support from senior management, 4) encourage mentees to become mentors, 5) recognize the relevance of the logic model framework for program planning and evaluation, and 6) identify the generalizable, educational components of the program to support care providers.

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Chapter 1: Background and Significance

Perinatal loss (PL) is the experience of losing a fetus or neonate between 20 weeks gestation and 28 days of life (Rondinelli, Long, Seelinger, Crawford & Valdez, 2015). PL is an expected or unexpected miscarriage, intra-uterine fetal demise, or stillbirth due to maternal, fetal, placental, or neonatal complications. In 2015, 2.7 million babies were reported stillborn globally (Shorey, Andre & Lopez, 2017). In Canada, the reported stillbirth rate is 8.0 per 1,000 births (Statistics Canada, 2013). Although the rate of stillbirth is on the decline, the phenomenon continues to occur (Shorey et al., 2017). Death is not routinely anticipated for the mother and fetus or newborn baby, although it does occur in childbirth (Shorey et al., 2017). The experience of losing a baby negatively affects the family, and thus, the provision of sensitive and empirically-based care for families experiencing a PL is important to minimize the long-term negative emotional and mental impacts (Ellis et al., 2016). Therefore, all health care providers (HCPs) that work within the perinatal specialty must anticipate palliative and bereavement care. Family doctors, obstetricians, midwives, and perinatal nurses (PNs) are the HCPs who may be needed to provide care to families experiencing a PL (Shorey et al., 2017).

The Family Experiencing a Perinatal Loss

The experience of PL is stressful and life altering for the parents, due to the loss of their baby (Koopmans, Wilson, Cacciatore & Flenady, 2013). In particular, the labor and delivery (L&D) process can have a significant effect on the parents experiencing a PL, due to the distressing process (O'Connell, Meaney & O'Donoghue, 2016). Perinatal nurses, as the point-of-care HCPs for the grieving parents, have a role as a resource and the main communicator between the family and the HCP team (Rondinelli et al., 2015). Families who receive little or no

support, after the birth of a baby who has died, face difficult circumstances (Ellis et al., 2016). Grieving parents are already at risk for psychological trauma, but their risk for negative outcomes increases if professional support is not available (Ellis et al., 2016). Therefore, examining how PNs are supported is valuable since they are key players for supporting the families experiencing a PL (Smart, Glass, Smith & Wright, 2013).

The Perinatal Nurse

PL is an emotionally intense process that affects nurses (Ellis et al., 2016; Parker, Swanson & Frunchak, 2014). While PL is recognized as an emotionally complex and potentially traumatic experience for the family, PNs also show signs of discomfort and emotional distress, while caring for families experiencing a PL (Ellis et al., 2016; Rondinelli et al., 2015). The reaction of nurses to perinatal death and the preparations for bereavement care are critical since PL can negatively affect them through psychological trauma, grief, and stress (Ellis et al., 2016; Shorey et al., 2017).

For PNs to provide individualized bereavement care, we must begin by examining the organizational, mentorship, and educational support that PNs receive. The literature is devoid of articles to support an evidence-based PL bereavement care nursing pathway, and publications dealing with nurse mentorship and support in this perinatal specialty could not be identified (Shorey, 2017). Meanwhile, current nursing care practices for bereaved parents, after a PL, are inconsistent (Ellis et al., 2016). The lack of consistency also suggests that PNs who are providing care to families experiencing a PL lack the necessary education and support (Ellis et al., 2016).

Mentorship

Mentoring is a dynamic process and an ongoing and reciprocal commitment between two or more individuals, with mutual learning goals that are applied through guidance, shared

knowledge, support, debriefing, and role modeling (Block, Claffey, Korow & McCaffrey, 2005; Shellenbarger & Robb, 2016). Mentoring can help promote nursing comfort, support, and teamwork; it is also valuable for enhancing nursing morale in workplace organizations (Block et al., 2005; Rondinelli et al., 2015). Although mentoring is commonly used for developing nursing students, it is also relevant to PNs who may be unfamiliar with PL and bereavement care or with palliative care settings (Hale & Phillips, 2019). When nurses become oriented to an unfamiliar specialty like bereavement care or palliative care, they can benefit from the support of a mentor to guide, share knowledge, listen, and debrief (Block et al., 2005). The purpose of mentorship is to promote positive career development outcomes for both experienced and new nurses (Block et al., 2005). Mentorship, thus, helps practicing nurses meet their goals and improves their leadership abilities, and is a feasible model for promoting nursing careers and organizational development (Block et al., 2005).

Novice Nurses in the Practice Setting

For this project, novice PNs are defined as new graduates, junior nurses, or nurses new to the perinatal specialty. Although novice PNs primarily focus on low risk and healthy labor and delivery experiences, labor and delivery patients may become high risk at any time, due to the unpredictable nature of the experience (Page & Mander, 2014). In tertiary care settings like British Columbia Women's Hospital (BCWH), novice PNs are expected to have the necessary skills to care for patients experiencing loss, after completing a one-day workshop on perinatal loss. The workshop focuses on the needs of families experiencing a PL and discusses interventions and the recommended support strategies to assist families. Novice PNs are neither exposed to PL during their perinatal nursing specialty practicums nor do they receive formal hands-on, one-to-one peer support from experienced nurse colleagues prior to providing

independent care. Instead, at BCWH, PNs are expected to independently provide patient care for families experiencing a PL and rely on the charge nurse and social worker for support and guidance, as necessary. Due to their lack of experience and exposure to PL, novice PNs often lack communication skills necessary for providing bereavement care, which can affect their ability to seek help or communicate with the charge nurse and social work team (Coyle et al., 2015). Using a retrospective, cross-sectional questionnaire survey, Wallbank and Robertson (2013) concluded that a low amount of nursing experience is related to higher nursing distress, which negatively affects the bereaved family experiencing a perinatal loss. This questionnaire survey supports the notion that perinatal nursing experience is associated with level of nursing distress, in the bereavement care context (Wallbank & Robertson, 2013). Since quality of care is important for nursing organizations, nurses should complete a structured hands-on program to become more educated about perinatal loss.

Purpose

The purpose of this scholarly practice advancement research (SPAR) project is to support optimal care for families experiencing a PL and promote a supportive work environment for PNs who are providing PL care, using nursing mentorship. The research question is: What components should be included in an empirically-based mentorship program to support and educate nurses about perinatal loss?

Significance

The rationale for this project is to improve: 1) the quality of care for parents who experience a PL; 2) the knowledge and skills of PNs caring for families experiencing a PL; and 3) the culture of nursing in the event of PL (Parker et al., 2014). The empirical literature and clinical practice experiences suggest that the following issues negatively affect patient care,

nursing morale, and staff retention in the perinatal specialty area: 1) organizational unresponsiveness: the overall lack of support for nurses, related to the care of families experiencing a PL; and 2) mentorship absence: the lack of mentoring and educational support for nurses learning to provide bereavement care (Ellis et al., 2016; Jonas-Simpson, McMahon, Watson & Andrews, 2010; Parker et al.,2014; Rondinelli et al., 2015; Steen, 2015). These issues suggest that leadership and mentorship are necessary to: 1) improve the support that PNs receive, and thus, potentially enhance their nursing knowledge and level of job satisfaction (Shellenbarger & Robb, 2016); and 2) improve patient outcomes and reduce post-traumatic stress for families experiencing a PL (Parker et al., 2014; Shellenbarger & Robb, 2016).

Short Summary of the Literature

The labor and delivery process associated with PL has lasting emotional and psychological effects on grieving parents, because of the stressful and profound nature of experiencing the death of a baby (Ellis et al., 2016; Parker et al., 2014). Ellis et al. (2016) conducted a systematic review of qualitative, quantitative, and mixed-methods studies that examined parents' and HCPs' experiences after stillbirth. The purpose of the review was to improve care for parents who experience stillbirth (Ellis et al., 2016). Based on the authors' findings, in 53% of the reported cases, the behaviors and actions of PNs had a lasting effect on the parents. Among these cases, 100% of the PNs mentioned emotional, knowledge, and system-based barriers to providing effective care to patients and families (Ellis et al., 2016). The systems-based barriers included hospital protocols and processes, which created barriers for individualized and holistic care. A lack of empirically-based, multi-professional training for all staff was also mentioned, which suggests that the perinatal nursing context necessitates improvements for the standards of bereavement care, training, and supportive working

environment for perinatal nurses (Ellis et al., 2016). The authors concluded that PNs, who provided privacy, continuity of care, and individualized care, and were empathetic and supportive of the parents' expression of their concerns could have a positive influence on the grieving parents (Ellis et al., 2016). A crucial finding in the review was that parents wanted improved training for PNs and a focus on care that was tailored to individualized family needs (Ellis et al., 2016). The authors suggested remedies to reduce the gaps in care such as improved training, continuity of care, supportive systems and structures, and clear care pathways (Ellis et al., 2016).

Research suggests that novice PNs are uncomfortable with bereavement care and their discomfort arises from their lack of preparation for working with families experiencing a PL (Parker et al., 2014) and/or lack of adequate education or support (Rondinelli et al., 2015). Experienced nurses tend to be assigned to care for families experiencing a PL because nursing leadership usually regards junior nurses as unprepared to manage PL (Parker et al., 2014). Thus, the more frequent exposure of experienced nurses to PL can cause PNs to suffer from compassion fatigue and burnout (Parker et al., 2014).

Evidence suggests that nursing morale in the maternity care setting is decreasing due to the lack of available support for PNs who are providing bereavement care (Parker et al., 2014). Furthermore, PNs in maternity care settings describe compassion fatigue and burnout when trying to provide adequate care to patients experiencing a PL (Lang et al., 2011). These conditions are especially important because nursing turnover in labor and delivery is already high, with other factors like the high demand work environment, shortage of staff and resources, and occupational stressors influencing nurses' retention (Nowrouzi et al., 2015; Page & Mander, 2014; Parker et al., 2014).

PNs provide one-to-one support for families experiencing a PL and they facilitate the in-patient bereavement care process for families (Rondinelli et al., 2015). Because of the large role played by PNs in a family's care, the support that PNs receive during and after the PL process should be carefully considered (Rondinelli et al., 2015). PNs have identified a lack of nursing support, experience, and education as contributing factors in their challenges to provide bereavement care (Shorey et al., 2017). To address these issues, PL should be considered in terms of the available empirical evidence to develop a mentorship program for PNs, with the aim of improving the morale and support available for nurses (Block et al., 2005; Roehrs, Masterson, Alles, Witt & Rutt, 2008; Rondinelli et al., 2015; Shorey et al., 2017).

Methodology

Kolb's theory.

Kolb's (1984) experiential learning theory is a framework for guiding the development of a PL mentorship program, which supports critically examining the PL literature and mentorship literature, to situate PL mentorship within the maternity care setting. Using Kolb's learning theory, the empirical evidence will be examined to develop components of a mentorship program for nurses caring for families with a PL.

Caring mentorship model.

A mentoring model based on caring philosophy and theory will be integrated and linked with Kolb's (1984) experiential learning theory (Wagner & Seymour, 2007). This theory brings together the relational humanistic model of mentorship with a caring framework, to develop the Caring Mentorship Model (Wagner, 2005b; Wagner & Seymour, 2007). This model will be integrated in order to promote understanding of its significance, and to further situate PL mentorship within the maternity care setting.

Keys Terms and Databases

The search terms that will be used to collect empirical evidence from the published literature include: perinatal loss, mentorship, nursing, organizational support, and education. These key terms will be used to identify literature from the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Educational Resources Information Center (ERIC) and the Cochrane Database of Systematic Reviews (CDSR). The literature selected on the basis of the search terms will be used to identify components of a mentorship program and content that could be used to support nurses working with patients experiencing a PL.

Advancement of Nursing Practice and Health Care

The SPAR project is linked to potential significant advances in perinatal nursing practice. It will address gaps in: 1) bereavement care provided by PNs; and 2) access to PL education for nurses. This SPAR project may affect perinatal cultures and nursing morale because burnout and compassion fatigue are significant nursing problems. The results have the potential to improve care for families (Ellis et al., 2016; Roehrs et al., 2008; Rondinelli et al., 2015).

The ultimate goal of this SPAR project is to improve PNs' care in the perinatal specialty area using PL mentorship. This SPAR project is a critical step in creating a culture of nursing that promotes teamwork and support, which can lead to improved job satisfaction and nursing retention (Parker et al. 2014; Shellenbarger & Robb, 2016).

Outline of SPAR Project Chapters

The first chapter of the project includes the background and significance, the purpose, a short summary of the literature, a brief introduction to the proposed method, and a description of how the SPAR project has potential to advance nursing practice and health care. Chapter two

includes a description of a theory on mentoring and, Kolb's (1984) experiential learning theory, and its relevance to mentoring. Chapter three includes the results of the literature search in terms of the numbers of papers identified from each database, the relevance of the selected articles, and some of their characteristics (e.g., date of publication and journal sources). Chapter three also presents the literature review as an analysis and critique, using the lens of Kolb's experiential learning theory, to look at the empirical literature on end-of-life care, death education, mentorship, and content considered critical for supporting excellent care in the context of PL. Chapter four describes the components and structure needed for a PL mentorship program. Lastly, Chapter five is a discussion of the contributions of the PL mentorship program and the implications for nursing practice.

Chapter 2: Kolb's Theory and Mentoring

This chapter describes Kolb's (1984) experiential learning theory, the theory of mentoring, and the relationship between Kolb's theory and mentoring. Kolb's experiential learning theory refers to various learning styles and learning stages and how they may be used to guide mentoring partnerships within the maternity care context. This chapter explores theoretical foundations of mentoring that incorporate caring theory and experiential learning from a nursing perspective. This lays the groundwork for the literature search and review of literature. For the purpose of this project, the term *mentee* is used synonymously with *learner* and *mentor* is used synonymously with *educator*.

Kolb's Theory

Kolb's (1984) theory of "experiential knowing" and learning is a middle range theory, based on the idea that learning is a process of experience, perception, cognition, and behavior (Lisko & O'Dell, 2010). Kolb's (1984) experiential learning theory has evolved from three other learning and development theories: 1) Dewey's philosophical pragmatism; 2) Lewin's social psychology theory; and 3) Piaget's cognitive-developmental genetic epistemology (Kavanaugh et al., 2009). Kolb's (1984) theory represents learning as a continuous process, instead of a singular outcome, which is grounded in and transformed by experience. Kolb claims that a person gains knowledge through discovery and experience, which produces an experiential learning cycle. Thus, Kolb's theory is relevant to the clinical learning environment for nurses who are in dynamic, hands-on settings (Kolb, 1984; Wain, 2017). The theory's holistic approach to the process of learning supports the idea that experience plays a crucial role in knowledge development (Lisko & O'Dell, 2010; Wain, 2017). Most importantly, the theory is a framework for all types of learners, because it emphasizes different learning styles to meet the needs of

diverse learners (Lisko & O'Dell, 2010). According to Kolb (1984), learning styles determine how an individual gains knowledge. This component of learning is important for mentors to understand so that they can create a valuable environment for mentees (Vinales, 2015). Therefore, to consider the components of a mentorship program, in the perinatal loss setting, the scope and foundation of Kolb's theory is explored.

Learning styles.

According to Kolb (1984), experiential learning occurs either through apprehension (participation in the real experience) or comprehension (through abstract conceptualization) (Lisko & O'Dell, 2010). Consequently, to aid the mentee's knowledge development, it is important they become familiar with their preferred learning style, between hands-on experience based learning or through abstract conceptualization, which are theoretical scenarios that use evidence to support decision making (Vinales, 2015). For learning to occur, mentees undergo a transformational process (Lisko & O'Dell, 2010). Kolb's (1984) theory asserts that a mentee's transformation occurs through extension (hands-on experience), intention (internal reflection on the experience) or both, concurrently (Lisko & O'Dell, 2010). The theory is comprised of four different learning styles: 1) accommodating: learning through apprehension and hands-on experience; 2) diverging: learning through apprehension and internal reflection of the experience; 3) converging: learning through comprehension and considering abstract ideas as separate from the actual experience; and 4) assimilating: learning through abstract conceptualization, but internalizing the learning (Lisko & O'Dell, 2010). Although many learners identify with more than one learning style, the style chosen by the learner is inherently how they approach a task; teachers' knowledge of the learning style is significant for promoting learning (Lisko & O'Dell, 2010).

Four-stage learning cycle.

Mentees complete four stages of experiential learning to develop new knowledge, skills, and attitudes: 1) concrete experience (CE) abilities – encountering a real life experience or task; 2) reflective observation (RO) abilities – making sense of what was encountered in the concrete experience through self-reflection and role model input; 3) abstract conceptualization (AC) abilities – making sense of concrete experience using theoretical examples and evidence to support theory; and 4) active experimentation (AE) abilities – applying new knowledge to future practice (Fewster-Thuente & Batteson, 2018; Kolb, 1984; Lisko & O'Dell, 2010; Vinales, 2015; Wain, 2017). Although Kolb (1984) recommended that each learner goes through each stage for the learning to be effective, learners often prefer to concentrate on only a few of the stages during the learning process (Kolb, 1984; Lisko & O'Dell, 2010). In any case, a major component of experiential learning theory is reflection (Wain, 2017). The theory asserts that some form of reflection is necessary, during or after the concrete experience, to develop critical thinking skills and bridge the gap between theory and practice (Wain, 2017).

Mentors and mentees need to familiarize themselves with the various learning styles and learning stages, to promote the understanding of self and others. Mentors also need to determine the various learning styles and stages, to help the mentee to move through the learning process. Meanwhile, mentees should determine their own learning style and stages of learning, for transparency about the learning process and to promote communication and an understanding of the terms and stages of learning during the mentor and mentee partnership. Therefore, Kolb's (1984) theoretical framework is significant for applying theory to practice, and the theory must be understood by both mentors and mentees, to promote communication and support the mentor-mentee partnership.

Theory on Mentoring and Caring Philosophy

Mentoring.

Mentoring is defined as "…a relational humanistic model that enriches clinical practice with deeper holistic focus on nurturing the whole person" (Morton-Cooper & Palmer, 1993; Verdejo, 2003; Wagner & Seymour, 2007; p. 201). Mentoring is a formal or informal partnership, in clinical, educational, leadership, and academic settings, between an expert and a novice with the purpose of fostering knowledge development; it includes the provision of personal and career-related guidance (Wagner & Seymour, 2007). While mentoring may be considered equal to precepting, it is a much more comprehensive role with a number of specific goals, namely: 1) supporting and guiding; 2) facilitating knowledge development through teaching; 3) role modeling; 4) counseling; and 5) advocating for the mentee (Vinales, 2015; Wagner & Seymour, 2007).

Stages of mentoring.

Based on a list proposed by Shaffer, Tallarica and Walsh (2000), mentoring is implemented in practice in four stages: initiation, cultivation, separation, and redefinition (Wagner & Seymour, 2007). Initiation, the first stage, requires the mentor and mentee to familiarize themselves with one another and set goals (Wagner & Seymour, 2007). Cultivation, the second stage, requires the mentor-mentee partners to share knowledge and work together on problem solving (Wagner & Seymour, 2007). Separation, the third stage, occurs when successful mentoring is complete, the partnership dissolves, and the individuals move forward in their own personal and professional lives (Wagner & Seymour, 2007). In the fourth stage, redefinition, the two individuals either mutually redefine the mentorship partnership as a friendship or they go their separate ways (Wagner & Seymour, 2007). This four-stage mentoring partnership develops

over time and can occur for a few months to several years (Wagner & Seymour, 2007). After the initial face-to-face interaction in a mentoring partnership, contact can continue in several ways, such as: telephone, email, or in-person (Wagner & Seymour, 2007).

Mentoring and nursing.

Mentoring is not a new concept to nursing, with reference to Florence Nightingale, who, during the Crimean Wars, may have been the first nurse mentor (Jacobs, 2018). Although the model was originally hierarchical and non-reciprocal, it has now evolved into a non-hierarchical and reciprocal partnership with a focus on novice and expert nurses (Jacobs, 2018). With mentoring being such a comprehensive and holistic approach to knowledge transfer, it has been noted as a way to maintain best practice, foster career development, and promote the job satisfaction and retention of nurses (Shaffer, Tallarica & Walsh, 2000; Wagner & Seymour, 2007).

Mentoring, caring and nursing.

Wagner (2005b) created a new model for mentoring based on a caring model, which emerged from the experiential encounters between experienced nurses and student nurses from two separate colleges (Wagner & Seymour, 2007). The combination of caring and mentoring are described as a means to develop healthy partnerships and create a positive and energetic environment (Wagner & Seymour, 2007). Caring is a foundational concept to nursing practice and it helps to redefine the concept of mentoring by looking at caring and mentoring from a nursing perspective (Wagner & Seymour, 2007).

Swanson's Theory of Caring

Swanson (1991) defined caring as "…a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility." Although Swanson's

(1991) middle range theory of caring is not addressed in the caring mentorship model, it is comparable to Gaut's (1983) interpretation of caring, which Wagner and Seymour (2007) refer to. Furthermore, Swanson's (1991) theory of caring is relevant to nursing in the context of stillbirth, because Swanson's theory of caring was derived from the lived experiences of women experiencing a miscarriage. Therefore, it is valuable to integrate Swanson's interpretation of caring into the mentoring lens used to examine the research question, in order to generate conclusions relevant to the maternity care context.

Swanson (1991) developed five categories of caring: 1) knowing – trying to understand how an event affects another; 2) being with – emotional presence or simply availability; 3) doing for – providing comfort and promoting dignity for an individual; 4) enabling – explaining information and supporting and validating another; and 5) maintaining belief – having faith in another's capacity to move forward (p. 162). These five processes of caring, according to Swanson (1991), are a means for nursing to care for another individual. Although Swanson (1991) focused primarily on the nurse-patient partnership, the five categories are highly relevant to a novice-expert nursing mentoring partnership. The five categories promote a caring and nurturing environment in which the mentee can learn and a means for the mentor to learn about the mentee beyond the cognitive domain (Wagner & Seymour, 2007). Swanson's (1991) five categories of caring are equivalent to the key traits of caring, identified by Wagner and Seymour (2007) as: "…honesty, respect, commitment of time and self and communication skills" (p. 202).

Swanson's (1991) theory of caring is similar to transformative caring mentioned by Wagner (2005b) in the caring mentorship model. The caring mentorship model (Wagner, 2005b) depicts competent transformative nurses or mentors and mentees as individuals who connect, empower one another, and learn from each other, with a non-hierarchical, reflective approach to

partnership. Swanson's (1991) theory of caring and, the caring described by Wagner and Seymour (2007) are valuable aspects to consider when examining mentoring in nursing.

Model of Caring Mentorship

The goal of the caring mentorship model is for two individuals in a mentorship partnership to share a connection and experience a transformative mentoring relationship (Wagner, 2005b; Wagner & Seymour, 2007). The model is characterized by knowing the self through reflection during and after an event (Wagner & Seymour, 2007). This process is intended to promote transformative caring and create a partnership that is mutually meaningful and empowering beyond the cognitive and affective level (Wagner & Seymour, 2007). To implement this mentoring model, the following qualities are necessary: ability to reflect and demonstrate knowledge of self, using a professional mentoring process, and using good communication skills (Wagner & Seymour, 2017).

The blend of caring and mentoring, as in the caring mentorship model, aims to promote a healthy working environment for nurses (Wagner & Seymour, 2007). For novice nurses, this mentoring model provides an opportunity to use team building and collaboration in a safe learning environment to gain independence in practice (Vinales, 2015; Wagner & Seymour, 2007). Expert nurses are able to: 1) create conditions that empower other nurses to mentor; 2) redefine their roles as mentors and leaders within their organization, and 3) continue to challenge their cognitive skills through best practice and continued education (Vinales, 2015; Wagner & Seymour, 2007).

Caring is integral to the design of effective mentorship, which is necessary to promote a caring nursing environment (Wagner & Seymour, 2007). Thus, both caring and mentoring are necessary and beneficial for a healthy nursing environment.

Kolb's Theory and Perinatal Loss

Kolb's (1984) experiential learning framework pertains to many learning environments since it includes observation, first-hand learning, and reflection. Within the context of a family experiencing a perinatal loss, the primary nurse provides bereavement care for the family (Rondinelli et al., 2015). For a novice nurse, who is learning to provide bereavement care, this experience can be highly distressing because the nurse is assumed to lack experience in delivering stillborn babies or providing comfort to a grieving family (Doherty et al., 2018; Rondinelli et al., 2015) that has suffered difficult and traumatic circumstances (Koopmans et al., 2013). Therefore, it is important to understand how nursing is affected, in the context of providing care to a family experiencing a perinatal loss, through each of Kolb's theory learning stages.

Didactic vs experiential learning.

Kolb's (1984) experiential learning theory, in the maternity care setting, is invaluable because it moves past the one-dimensional classroom-based didactic learning that is traditionally presented to novice nurses, and invites consideration of the clinical and hands-on setting, in partnership with a mentor (Fewster-Thuente & Batteson, 2018; Kavanaugh et al., 2009; Rondinelli et al., 2015). Although didactic learning is important for understanding the theoretical aspects of pregnancy, pregnancy-related complications, and perinatal loss, on its own it is insufficient to prepare nurses to provide care for bereaved families (Doherty et al., 2018).

Novice nurses are present for patients and families during the labor, delivery, and end-of-life care relating to perinatal loss, which can be overwhelming for those who have never provided care to parents and families experiencing a perinatal loss (Doherty et al., 2018; Rondinelli et al., 2015). In this context, the mentor-mentee partnership is vital for novice nurses

to observe, reflect, and experience caring for this demographic group, while being able to debrief and work through the emotions of providing end-of-life care to a family (Armitage, 2010; Doherty et al., 2018; Kavanaugh et al., 2009; Rondinelli et al., 2015; Wain, 2017). The process is a means to move beyond didactic learning and into experiential learning, through mentorship, while promoting nursing support and meaningful bereavement care for families (Kavanaugh et al., 2009; Rondinelli et al., 2015).

Reflective observation.

Reflection is defined as "…a philosophical understanding of how we gain knowledge through experience" (Johns, 2009; Wain, 2017, p. 662). Reflective observation, reflection with self and mentor after observation, or debriefing with the mentor, is a major component of experiential learning and is a way to facilitate understanding of theory and practice (Wain, 2017; Vinales, 2015).

Reflection-in-action is made possible by thinking about the experience as the event occurs and deciding on how to act, immediately (Wain, 2017). Meanwhile, reflection-on-action occurs after the event when the individual reflects on the experience following the event (Wain, 2017). In this process, individuals think about what they will do differently or the same, in the future, and how theory informs their practice and helps them in processing their emotions (Wain, 2017). This process helps the mentor and mentee learn about themselves, how the experience shapes their development as nurses and care providers, their personal relationship, and their role in the process of pregnancy and perinatal loss, end-of-life care and death and dying for the bereaved parents and family (Wain, 2017).

Reflective practice is also a process of learning and questioning one's own values, attitudes, and assumptions to further develop one's role in relation to the nursing team and

patients (Wain, 2017). The process of reflection and debriefing is important for the mentee's cognitive learning and communications that involve open discussion of clinical issues and barriers to practice with the mentor. Reflection, as a result, is a two-way process that is also meant to help the mentor to: 1) support the mentee through debriefing; and 2) understand the clinical issues that may come up for the mentee (Armitage, 2010). Therefore, reflective practice is significant to cultivate a supportive environment for perinatal nurses, so they may have the awareness to self-improve and learn to provide safe and compassionate, family-centered care (Wain, 2017).

Abstract conceptualization.

Kolb's (1984) third stage, abstract conceptualization, occurs when the mentee tries to make sense of the experience and make interpretations to promote learning (Wain, 2017). This process occurs through debriefing between the mentor and mentee (Fewster-Thuente & Batteson, 2018). Reflection and debriefing validate one's feelings and progress through the experience of caring for a family experiencing a perinatal loss (Doherty et al., 2018; Kavanaugh et al., 2009; Vinales, 2015; Wain, 2017). Debriefing is essential for the communication between the mentor and mentee, which helps the mentor assess the mentee's thought processes and probe the mentee with questions to promote critical thinking (Lisko & O'Dell, 2010; Kavanaugh et al., 2009; Vinales, 2015). Meanwhile, mentees can use the debriefing time to connect what they learn in theory with practice to demonstrate their understanding and knowledge development (Fewster-Thuente & Batteson, 2018). Thus, the mentorship partnership, through debriefing, is vital to determine the mentee's ability to form abstract conceptualizations from concrete evidence and theory and apply it to practice (Vinales, 2015).

Active experimentation.

The last stage in Kolb's (1984) experiential learning theory infers that for knowledge development to come full circle, mentees must apply what they learn from theory and practice through the reflection and debriefing process (Vinales, 2015). This step requires mentees to openly discuss what they will do in practice, after connecting theory and their previous practice experience with evidence to support their chosen route of action (Vinales, 2015). The mentor's role is to facilitate learning through the use of open communication, effective interpersonal skills, honesty, and compassion and demonstrate commitment to support the mentee, which is in accordance with the mentor's attributes based on the model of caring mentorship for nursing (Wagner & Seymour, 2007).

The four stages of experiential learning are a means to assess the mentee's cognitive learning process, and thus, are an invaluable aspect of knowledge development for mentees that will positively affect patient care (Fewster-Thuente & Batteson, 2018). The experiential learning theory is beneficial, in the context of perinatal loss, because it emphasizes: 1) application of theory; 2) hands-on clinical practice and experience; 3) reflection about self and surroundings; 4) debriefing with mentor; and 5) formulation of a plan of care and developing insight, by connecting theory and practice and using evidence to support ways for improving future practice (Kavanaugh et al., 2009).

Relevance of Kolb's Theory

Death education and support for health professionals when giving end-of-life care is relatively new but a number of programs are in place in the US, like the Toolkit for Nurturing Excellence at the End of Life – Nurse Educators and the Initiative for Pediatric Palliative Care (Kavanaugh et al., 2009). Although death education and support for nurses in the context of

perinatal loss is new to the maternity care setting, Kolb's theory has been used in face-to-face and online blended courses on dying, loss, and grief, indicating its possible application and relevance to the perinatal loss setting (Kavanaugh et al., 2009).

Kolb's Theory and Mentoring

Based on the literature, the theory of mentoring and Kolb's theory of experiential learning are linked and share many similarities. To begin, experiential encounters with two individuals have led to the creation of mentoring in numerous settings (Wagner & Seymour, 2007), with the development of the caring mentorship model. Other linkages between Kolb's theory and mentoring include: 1) holistic practice; 2) the value of reflection; 3) bringing together novice and expert roles; and 4) bridging theory and practice (Fewster-Thuentes & Batteson, 2018; Kolb, 1984; Kavanaugh et al., 2009; Lisko & O'Dell, 2010; Vinales, 2015; Wagner & Seymour, 2007). To further situate Kolb's theory and mentoring in the theoretical groundwork for a perinatal loss mentorship program, we need to explore their inter-relatedness.

Holistic practice.

According to Kolb's (1984) theory of experiential learning, the four-stage learning cycle requires a holistic approach to process learning (Lisko & O'Dell, 2010). Concrete experience, reflection, abstract conceptualization, and active experimentation are the four stages of learning that come together to promote concept knowledge development (Lisko & O'Dell, 2010). Because the learning stages address cognitive and affective elements through physical encounters, retrospective learning, reflective observation, and connection of concepts, the learning process is a holistic experience (Kolb, 1984; Lisko & O'Dell, 2010).

Mentoring is also a holistic experience, because its goal is to develop the 'whole' person (Wagner & Seymour, 2007). Mentoring is a relational experience between individuals and the

experience of forming, establishing, and culminating relations in the mentoring process is used to transfer knowledge between the mentor and mentee (Wagner & Seymour, 2007). As learning and partnership formation come together in a mentoring experience, the individual can be fully understood as a whole (i.e., a holistic encounter) (Wagner & Seymour, 2007).

Reflection.

According to Kolb (1984), the knowledge development process is not passive for the mentee, who is an active participant in the learning process (Fewster-Thuente & Batteson, 2018). The mentor uses a non-hierarchical and collaborative approach to mentoring, as a means to promote active participation in the mentoring partnership (Fewster-Thuentes & Batteson, 2018). Active participation is a key component of reflection, which is an important learning stage (Fewster-Thuente & Batteson, 2018; Wain, 2017). Self-reflection and debriefing with the mentor are critical in the four-stage learning cycle and are implemented by the mentee in reflecting on the experience, drawing conclusions, and making decisions for future practice, in collaboration with the mentor (Fewster-Thuente & Batteson, 2018). Reflection is used in the process of self-reflection and debriefing with the mentor, and thus, is a significant part of Kolb's experiential learning theory (Fewster-Thuente & Batteson, 2018).

Mentoring, and specifically the caring mentorship model, asserts that to successfully mentor or be mentored, participants must 'know thyself,' through self-reflection and debriefing (Wagner & Seymour, 2007). This process speaks to both mentors and mentees in the learning and educating process, before and after an event or observation (Wagner & Seymour, 2007). Wagner and Seymour (2007) state that reflection between mentors and mentees fosters a positive environment for mentees to grow cognitively and vocalize their fears and emotions. The process

can also empower mentors to further develop their interpersonal and communication skills and use reflection and debriefing to determine the needs of the mentee (Wagner & Seymour, 2007).

Novice and expert roles.

Both Kolb's (1984) experiential learning theory and the theory of mentoring emphasize the roles of being a novice and being an expert (Kavanaugh et al., 2009; Vinales, 2015; Wagner & Seymour, 2007). Experiential learning and the theory of mentoring also both focus on the transfer of knowledge, which requires the roles of a novice and an expert (Kavanaugh et al., 2009; Vinales, 2015; Wagner & Seymour, 2007). Experience is central to both theories, and to develop experience, mentors (educators) must have experience and mentees (learners) need to have further experience (Vinales, 2015; Wagner & Seymour, 2007). Both theories highlight the importance of collaboration, even though the novice and expert roles are well defined, which supports the idea that both Kolb's (1984) experiential learning theory and the theory of mentoring are linked and can be used concurrently (Fewster-Thuentes & Batteson, 2018; Harvey & Uren, 2019; Kavanaugh et al., 2009; Vinales, 2015; Wagner & Seymour, 2007).

Bridging Theory and Practice

The theory of mentoring and Kolb's (1984) experiential learning theory both infer that bridging theory and practice can take place together, through reflection, active participation, and hands-on learning, as a means to promote cognitive thought processes (Harvey & Uren, 2019; Kavanaugh et al., 2009; Wagner & Seymour, 2007; Wain, 2017). Linking theory to practice not only addresses cognitive development, but also helps to identify nursing problems such as support, resources, and the readiness to provide care (Doherty et al., 2018). Bridging theory to practice is a means to enhance learning, promote communication among mentors, mentees and patients, and create a supportive learning environment (Vinales, 2015). The two theories

emphasize bridging theory with practice through the experiential learning process, further indicating their inter-relatedness (Jacobs, 2018; Kavanaugh et al., 2009; Wagner & Seymour, 2007).

Summary

Chapter two provides the foundation for the theoretical framework of the SPAR project. This chapter's comprehensive emphasis on the nuances of mentorship partnerships and experiential learning theory explicates and identifies their linkages and use in practice-based settings. The themes that develop from the theoretical findings of this chapter lay the foundation for the literature review and analyses presented in Chapter three.

Chapter 3: Review of Literature

Chapter three consists of a brief summary of my literature search and presents my synthesis of literature. The purpose of the literature search is to support literature synthesis, which represents analysis and criticism of the empirical literature on mentorship and nursing education for end-of-life and bereavement care. I used CINAHL, ERIC, and the Cochrane Library (Ovid) databases for the literature search, choosing CINAHL as the primary database for the literature search due to its extensive collection of nursing journal articles. I used ERIC, an educational resource database, due to the project's focus on education. Lastly, I used the Cochrane Library database for its collection of systematic reviews, which, when relevant, can contribute to rigor.

My literature search provided a number of papers identified from each database. The next section specifies the relevance of the selected articles, and some of their defining characteristics, in accordance with the inclusion and exclusion criteria. The inclusion and exclusion criteria vary slightly for each database and so, will be discussed within respective subsections.

Literature Search

CINAHL.

For the CINAHL search, the keywords and phrases included: 1) mentor or mentorship, 2) nurse, nurses, or nursing, and 3) hospice, palliative nursing, palliative care, end-of-life care, terminal care, bereavement, grief or loss, mourning or death, supportive care, anticipatory grieving or chronic sorrow, complicated grief, perinatal loss, stillbirth, perinatal death, miscarriage or spontaneous abortion, habitual abortion, incomplete abortion, and cervical incompetence. The search terms were used to expand the number of papers dealing with all kinds of grief and the grief and loss associated with perinatal death.

Using the search terms, I identified 121 sources. The inclusion criteria for the CINAHL search were journal articles, and dissertations and thesis work, with dates of publication between 2008 and 2018. Student nurses and new graduate nurses were included under the nursing umbrella, because their experiences and skillset are potentially similar to those of a novice nurse (Chen & Lou, 2014). I added parameters for dates of publication as last ten years because contexts change and sources beyond ten years from publication may not be as relevant to my purpose.

The exclusion criteria for the CINAHL database search were consulting, palliative care services, focus or scope other than bedside nursing, and anecdotal writing and summaries, editorials, and biographies. Although it would be useful to examine other disciplines like midwifery and social work, I kept the scope specific to nursing to hone in on recommendations that are specific to nurses, in the context of bereavement care education. I excluded anecdotal work, editorial work, and biographies due to their reliance on a single case or small sample sizes; they tend to reduce considerations of generalizability.

Based on the inclusion criteria, 51 journal sources were identified, and using the exclusion criteria, 32 journal sources were relevant. I omitted all of the dissertation sources due to their lack of relevance to the project purpose.

ERIC.

I used the ERIC database because it is an extensive resource for education-related topics, which aligns with this project's emphasis on nursing education and mentoring. This database was particularly important for examining all nursing specialities where education and mentorship have helped learners succeed and feel more supported, at the bedside. The search terms for the ERIC database were: 1) education, mentoring, mentorship, mentor, mentor program, mentoring

program; 2) nursing; and 3) death and dying, death education, end-of-life, and palliative care. Because the ERIC database primarily deals with education, the search terms were focused on general nursing, and death and dying, to keep the search broad and to maximize the number of search results. This database is important to consider the death-education related strategies used in other nursing-specific settings, to add value to perinatal loss management.

Using the search strategy, I identified 104 sources from the ERIC database. The inclusion criteria were journal articles, dissertations and theses, date of publication between 2008 and 2018, nursing scope, nursing students and new graduate nurses, educational needs, mentoring, mentorship, mentor, death and dying, death education, end-of-life care, and palliative care. The inclusion criteria aligned with the CINAHL criteria and types of journal sources, to maintain a standard for the inclusion criteria in the literature review.

The exclusion criteria were: distance education learning, practice outside of nursing scope, anecdotal work, summaries and biographies, and personal loss as experience. The exclusion criteria aligned with the CINAHL exclusion criteria. I excluded distance education learning because the SPAR project is focused on experiential learning, making distance education learning irrelevant to the project's purpose. I excluded the anecdotal and personal experiences due to constraints on generalizability, which could affect the rigor of the literature review. Based on the inclusion criteria, I identified 27 journal sources and, after applying the exclusion criteria, I selected 12 journal sources for the literature review from the ERIC database. Of these, five were dissertation and thesis work sources. The selected dissertations and thesis sources were highly relevant to the project's purpose.

Cochrane database of systematic reviews (Ovid).

I also used the Cochrane database of systematic reviews for the literature search due to the rigor that systematic reviews add. The Cochrane database collates empirical literature to identify the strength of support for different evidence-based practices. The search terms were: 1) perinatal loss, stillbirth, perinatal death, miscarriage, spontaneous abortion, bereavement, grief or loss, mourning, death, care or support, hospice or palliative nursing, palliative care, end-of-life care, terminal care; and 2) mentor, mentorship, mentoring, nurse, nurses and nursing. I included perinatal loss and death in the search terms to find sources relevant to the healthcare context. I included general bereavement and loss to examine management of care outside the maternity care setting, as a means to consider themes and concepts that may potentially have been overlooked in the perinatal specialty.

My search strategy produced three published sources. The inclusion criteria were date of publication between 2008 and 2018, palliative and end-of-life care, perinatal loss, mentorship, support programs, and bereavement care. The nursing discipline was not part of the inclusion criteria due to the small number of search results. I deemed it feasible to consider how support and/or mentorship programs affect other disciplines that, like nursing, provide support for patients and families within the palliative care context.

The exclusion criteria were patient or client focus, because the literature review needed to emphasize the general caregiver. After applying the inclusion and exclusion criteria, I identified one systematic review from the Ovid platform for the Cochrane database. Using a systematic review for the review of literature is beneficial since the empirical evidence it provides would promote the rigor of the findings.

CINAHL	ERIC	Cochrane Database
Adams, C. C. (2009). The leadership of Florence Wald: Listening to the voices of the early hospice founders and colleagues. *Illness, Crisis & Loss*, *17*(4), 379-398.	Ayed, A., Sayej, S., Harazneh, L., Fashafsheh, I., & Eqtait, F. (2015). The nurses' knowledge and attitudes towards the palliative care. *Journal of Education and Practice*, *6*(4), 91-99.	Horey, D., Street, A. F., O'Connor, M., Peters, L., & Lee, S. F. (2015). Training and supportive programs for palliative care volunteers in community settings. *Cochrane Database of Systematic Reviews*, (7).
Adams, C. (2010). Dying with dignity in America: The transformational leadership of Florence Wald. *Journal of Professional Nursing*, *26*(2), 125-132.	Foltz-Ramos, K. (2017). *When the simulator dies: Experiential education about death designed for undergraduate nursing students*. Buffalo, NY.	
Arbour, R. B., & Wiegand, D. L. (2014). Self-described nursing roles experienced during care of dying patients and their families: A phenomenological study. *Intensive and Critical Care Nursing*, *30*(4), 211-218.	Hales, B. M., & Hawryluck, L. (2008). An interactive educational workshop to improve end of life communication skills. *Journal of Continuing Education in the Health Professions*, *28*(4), 241-255.	
Crawford, D., Corkin, D., Coad, J., & Hollis, R. (2013). Educating children's nurses for communicating bad news. *Nursing Children & Young People*, *25*(8).	Jones, S. L. (2016). Nurses' Occupational Trauma Exposure, Resilience, and Coping Education. (Doctoral dissertation, Walden University).	
Doucette, E., Killackey, T., Brandys, D., Coulter, A., Daoust, M., Lynsdale, J., & Shamy-Smith, E. (2014). Silent witnesses: Student nurses' perspectives of advocacy and end-of-life care in the intensive care unit. *Dynamics*, *25*(4), 17-21.	Kopp, M. L. (2014). Active teaching strategies for a sense of salience: End-of-life communication (Indianapolis, Indiana).	
Drenth, C., Sithole, Z., Pudule, E., Wüst, S., Gunn-Clark, N., & Gwyther, L. (2018). Palliative care in South Africa. *Journal of Pain and Symptom Management*, *55*(2), S170-S177.	Koren, M. E., Hertz, J., Munroe, D., Rossetti, J., Robertson, J., Plonczynski, D., ... & Ehrlich-Jones, L. (2008). Assessing students' learning needs and attitudes: considerations for gerontology curriculum planning. *Gerontology & Geriatrics Education*, *28*(4), 39-56.	
Evans, R. (2012). Emotional care for women who experience miscarriage. *Nursing Standard (through 2013)*, *26*(42), 35.	Niederriter, J. E. (2009). *Student nurses' perception of death and dying* (Doctoral dissertation, Cleveland State University).	

Ferrell, B., Virani, R., Paice, J. A., Coyle, N., & Coyne, P. (2010). Evaluation of palliative care nursing education seminars. *European Journal of Oncology Nursing*, *14*(1), 74-79.	Pye, S. E. (2016). *Making a Difference: Evidence Based Palliative Care Education for Neonatal Nurses.* (Doctoral dissertation, Walden University).	
Gillett, K., O'Neill, B., & Bloomfield, J. G. (2016). Factors influencing the development of end-of-life communication skills: A focus group study of nursing and medical students. *Nurse Education Today*, *36*, 395-400.	Richeson, N. E., White, P., Nadeau, K. K., Chessa, F., Dreher, G. K., Frost, C., ... & Todorich, P. (2008). Geriatric, ethics, and palliative care: Tending to the mind and spirit. *Educational Gerontology*, *34*(7), 627-643.	
Hartley, J. (2011). Enhancing Competence and Culture in Providing End-of-Life Comfort Care in the Intensive Care Unit. *Critical Care Nurse*, *31*(2), E26-E26.	Rodriquez, J. (2009). Attributions of agency and the construction of moral order: Dementia, death, and dignity in nursing-home care. *Social Psychology Quarterly*, *72*(2), 165-179.	
Haugan, G, & Hanssen, I. (2012). Familiarity knowledge in student nurses' clinical studies: Exemplified by student nurses in palliative care. *Research and Theory for Nursing Practice*, *26*(2), 95.	Sweeney, C., O'Sullivan, E., & McCarthy, M. (2015). Keeping it real: Exploring an interdisciplinary breaking bad news role-play as an integrative learning opportunity. *Journal of the Scholarship of Teaching and Learning*, 14-32.	
Howe, J. B., & Scott, G. (2012). Educating prison staff in the principles of end-of-life care. *International Journal of Palliative Nursing*, *18*(8), 391-395.	Temkin-Greener, H., Zheng, N., Norton, S. A., Quill, T., Ladwig, S., & Veazie, P. (2009). Measuring end-of-life care processes in nursing homes. *The Gerontologist*, *49*(6), 803-815.	
Hutti, M. H. (2015). A comparison of the caring processes used by obstetric, surgical, and emergency nurses when caring for the woman with a fetal loss. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *44*(s1), S69-S69.		
Kataoka-Yahiro, M. R., McFarlane, S., Koijane, J., & Li, D. (2017). Culturally competent palliative and hospice care training for ethnically diverse staff in long-term care facilities. *American Journal of Hospice and Palliative Medicine*, *34*(4), 335-346.		

King-Okoye, M., & Arber, A. (2014). 'It stays with me': The experiences of second-and third-year student nurses when caring for patients with cancer. *European Journal of Cancer Care*, *23*(4), 441-449.		
Lavoie, M., Blondeau, D., & Martineau, I. (2013). The integration of a person-centered approach in palliative care. *Palliative & Supportive Care*, *11*(6), 453-464.		
Levine, S., O'Mahony, S., Baron, A., Ansari, A., Deamant, C., Frader, J., ... & Preodor, M. (2017). Training the workforce: Description of a longitudinal interdisciplinary education and mentoring program in palliative care. *Journal of Pain and Symptom Management*, *53*(4), 728-737.		
Lewis, S. L., & Ahern, K. (2017). Exploring NICU nurses' affective responses to end-of-life care. *Advances in Neonatal Care*, *17*(2), 96-105.		
Mahler, A. (2010). The clinical nurse specialist role in developing a gero-palliative model of care. *Clinical Nurse Specialist*, *24*(1), 18-23.		
Malloy, P., Thrane, S., Winston, T., Virani, R., & Kelly, K. (2013). Do nurses who care for patients in palliative and end-of-life settings perform good self-care? *Journal of Hospice & Palliative Nursing*, *15*(2), 99-106.		
Murakami, M., Yokoo, K., Ozawa, M., Fujimoto, S., Funaba, Y., & Hattori, M. (2015). Development of a neonatal end-of-life care education program for NICU nurses in Japan. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *44*(4), 481-491.		
Nyatanga, B. (2012). Looking after everyone except yourself: The double-edged sword of		

caring. *British Journal of Community Nursing*, *17*(3), 109-109.		
Olausson, J., & Ferrell, B. R. (2013). Care of the body after death. *Clinical Journal of Oncology Nursing*, *17*(6).		
Parry, M. (2011). Student nurses' experience of their first death in clinical practice. *International Journal of Palliative Nursing*, *17*(9), 448-453.		
Pitman, S. (2013). Evaluating a self-directed palliative care learning package for rural aged care workers: A pilot study. *International Journal of Palliative Nursing*, *19*(6), 290-294.		
Quinn, K., & Hudson, P. (2014). Establishing a nurse practitioner collaborative: Evolution, development, and outcomes. *International Journal of Palliative Nursing*, *20*(9), 457-461.		
Ramasamy Venkatasalu, M., Whiting, D., & Cairnduff, K. (2015). Life after the Liverpool care pathway (lcp): A qualitative study of critical care practitioners delivering end-of-life care. *Journal of Advanced Nursing*, *71*(9), 2108-2118.		
Ranse, K., Yates, P., & Coyer, F. (2012). End-of-life care in the intensive care setting: A descriptive exploratory qualitative study of nurses' beliefs and practices. *Australian Critical Care*, *25*(1), 4-12.		
Steven, A., White, G., Marples, G., & Atkinson, J. (2014). End of life care: An educational pathway for community nurses. *Primary Health Care*, *24*(1), 18-25.		
Terry, L. M., & Carroll, J. (2008). Dealing with death: First encounters for first-year nursing students. *British Journal of Nursing*, *17*(12), 760-765.		

Vanderspank-Wright, B., Fothergill-Bourbonnais, F., Malone-Tucker, S., & Slivar, S. (2011). Learning end-of-life care in ICU: Strategies for nurses new to ICU. *Dynamics (Pembroke, Ont.)*, *22*(4), 22-25.		
Virani, R., Malloy, P., Dahlin, C., & Coyne, P. (2014). Creating a fabric for palliative care in safety net hospitals: end-of-life nursing education consortium for public hospitals. *Journal of Hospice & Palliative Nursing*, *16*(5), 312-319.		

Summary of the Literature Search

The literature search provided the foundation for my synthesis of the literature, which is critical to address the project's purpose. A significant finding from the literature, for all three databases, is that evidence about perinatal loss and nursing mentorship support is lacking. The paucity of information underscores the need to consider how mentorship and death education come together in other palliative care settings, as a means to support nurses. Thus, to address the problem, I included literature about death and dying and bereavement care in other specialties like gerontology, neonatal intensive care, adult intensive care, adult medicine, and pediatrics.

Review of Literature

In the remainder of this chapter, I present my synthesis which involves analysis and critique of the empirical findings on end-of-life care and mentoring in the perinatal setting. The analysis uses the lens of Kolb's experiential learning theory. I used a content theme and processes approach to distinguish the overarching themes from the processes, in the literature. The primary themes that I identified are: 1) end-of-life care and perinatal nursing; 2) emotional stressors; 3) coping mechanisms; and 4) emotional labor and emotional intelligence. To better understand the relationships between end-of-life care, support, and education, five processes were generated and situated in the context of perinatal bereavement care. The processes are: 1) grief counselling and bereavement support; 2) end-of-life care communication skills; 3) reflection and debriefing; 4) collaborative learning and decision-making; and 5) didactic and experiential learning.

Experiential learning, Kolb's theory, and mentoring in end-of-life care repeatedly arises in the literature, which supports their respective relevance to death education and end-of-life care in any health care context, including the perinatal setting (Evans, 2012; Jones, 2016;

Vanderspank-Wright, Fothergill-Bourbonnais, Malone-Tucker & Slivar, 2011). Furthermore, nurses spend the most time with patients and families, in all phases of life, including palliative and the end-of-life care, where death may be expected or unexpected (Ayed, Sayej, Harazneh, Fashafsheh & Eqtait, 2015; Doucette et al., 2014; Foltz-Ramos, 2017). Therefore, to determine how to support and educate nurses, it is important to analyze how the themes and processes associated with end-of-life care and mentoring translate across nursing specialties, like the perinatal setting.

End-of-life care and perinatal nursing.

Nurses, whether novice or expert, routinely provide end-of-life care to patients and families in non-hospice specialities such as perinatal care (Evans, 2012; Ranse, Yates & Coyler, 2012). The literature suggests that previous education and training and continuing education that nurses receive about end-of-life care is inconsistent and lacking in non-palliative specialty settings (Howe & Scott, 2012; Lewis & Ahern, 2017; Mahler, 2010; Malloy, Thrane, Winston, Virani & Kelly, 2013; Murakami et al., 2015; Ranse et al., 2012). Although a shortage of literature specific to end-of-life care exists in the perinatal setting, the findings suggest that palliative education has components that are relevant and can be generalizable to other specialties like perinatal nursing (Drenth, 2018; Evans, 2012; Foltz-Ramos, 2017; Jones, 2016; Koren et al., 2008; Mahler, 2010; Malloy et al., 2013; Niederriter, 2009; Parry, 2011; Pitman, 2013; Pye, 2016).

Paucity of death education.

Evidence indicates that lack of end-of-life care education and continuing education for nurses is negatively affecting nurses and nursing morale, and consequently, the quality of patient care and the family experience (Ayed et al., 2015; Drenth et al., 2018; Foltz-Ramos, 2017;

Murakami et al., 2015; Niederriter, 2009; Olausson & Ferrell, 2013; Pitman, 2013; Pye, 2016; Ranse et al., 2012; Steven, White & Marples, 2014; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani, Malloy, Dahlin & Coyne, 2014). Therefore, a paucity of death education is a problem that needs to be addressed, to improve quality of patient and family care and nursing morale (Evans, 2012; Foltz-Ramos, 2017; Kataoka-Yahiro, McFarlane, Koijane & Li, 2017; Malloy et al., 2013; Nyatanga, 2012). Notwithstanding, the empirical findings indicate that a need exists for perinatal nurses to understand end-of-life care and its relationship to the perinatal setting, through access to death education (Adams, 2009, 2010; Evans, 2012; Foltz-Ramos, 2017; Kataoka-Yahiro et al., 2017; Nyatanga, 2012; Ramasamy Venkatasalu, Whiting & Cairnduff, 2015). Access to death education for perinatal nurses is important to promote an environment that endorses quality end-of-life care for patients and families and support for perinatal nurses (Adams, 2009, 2010; Evans, 2012; Foltz-Ramos, 2017; Kataoka-Yahiro et al., 2017; Nyatanga, 2012; Ramasamy Venkatasalu et al., 2015).

End-of-life care and holistic care.

Holistic care encompasses addressing the 'whole', with consideration of emotional, spiritual, physical, psychosocial and cultural care needs of the bereaved patient and family (Adams, 2009; Ayed et al., 2015; Evans, 2012; Drenth et al., 2018; Ferrell, Virani, Paice, Coyle & Coyne, 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Pitman, 2013; Steven et al., 2014). A holistic approach to end-of-life care was moved forward with Florence Wald's conceptualization that death and dying, whether anticipated or not, require integration of psychological, spiritual and physiological needs of the patient and a consideration of the family (Adams, 2009, 2010). The conceptualization provided a foundation for end-of-life care, which is now recognized as providing care while considering the: 1) Physical domain, i.e., pain

management; 2) Emotional domain, i.e., assessment of patient and family emotional needs, demonstrate nursing presence and provide emotional support; 3) Psychosocial and socio-cultural domains, i.e., support in the identification of financial resources and consider cultural needs and; 4) Spiritual domain, i.e., discuss and provide access to spiritual care needs, for the patient and family (Ayed et al., 2015; Drenth et al., 2018; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Niederriter, 2009; Nyatanga, 2012; Richeson et al., 2008; Steven et al., 2014).

Evidence suggests that perinatal loss is a circumstance in which nurses are more likely to focus on the physical aspects of care, possibly overlooking the holistic domains of care, in the end-of-life care context (Evans, 2012; Hutti, 2015). The significance of a holistic approach to end-of-life care for perinatal loss, is situated in understanding that end-of-life care requires a comprehensive set of nursing skills that go beyond the physical domain (Ayed et al., 2015; Adams, 2009; Evans, 2012; Drenth et al., 2018; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Pitman, 2013; Steven et al., 2014). A perinatal loss, whether anticipated or not, is a seldom spoken death experience, by the bereaved family, and is thus, a form of grief that is often overlooked and poorly understood by society (Evans, 2012; Niederriter, 2009). Therefore, to better understand the needs of and whole experience for the bereaved family, it is especially important for perinatal nurses to integrate all the holistic domains of care into practice (Adams, 2009; Ayed et al., 2015; Evans, 2012; Drenth et al., 2018; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Pitman, 2013; Steven et al., 2014). Notably, whether a bereaved family experiences an anticipated or unanticipated loss, holistic care in the end-of-life care context is relevant. Because each grief experience is unique, it is critical to be all-inclusive in the care provided so as to better determine how to support the bereaved family (Adams, 2009, 2010;

Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Niederriter, 2009; Richeson et al., 2008; Steven et al., 2014).

Accordingly, awareness and education and the integration of holistic, end-of-life care is providing comprehensive nursing care by assessing and asking open-ended questions that are meant to help the perinatal nurse to recognize the needs and wishes of the bereaved family, which is synonymous with making end-of-life care meaningful for the patient and family (Adams, 2010; Ferrell et al., 2010; Gillett, O'Neill & Bloomfield, 2016; Howe & Scott, 2012; Lewis & Ahern, 2017; Nyatanga, 2012; Pye, 2016; Richeson et al., 2008; Steven et al., 2014). Holistic, end-of-life care incorporates all realms of individualized care, including high quality, compassionate, respectful and dignified care, for the whole person and family (Adams, 2010; Ferrell et al., 2010; Gillett et al., 2016; Howe & Scott, 2012; Lewis & Ahern, 2017; Nyatanga, 2012; Pye, 2016; Richeson et al., 2008; Steven et al., 2014).

Emotional stressors.

Although effective end-of-life care promotes quality care for patients and families, it can raise many emotional reactions for nurses, such as: 1) emotional exhaustion; 2) compassion fatigue and burnout; 3) moral distress; 4) discomfort; and 5) fear of death (Arbour & Wiegand, 2014; Crawford, Corkin, Coad & Hollis, 2013; Doucette et al., 2014; Evans, 2012; Gillett et al., 2016; Horey et al., 2015; Jones, 2016; King-Okoye & Arber, 2014; Levine et al., 2017; Lewis & Ahern, 2017; Malloy et al., 2013; Niederriter, 2009; Nyatanga, 2012; Ranse et al., 2012; Rodriguez, 2009; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Emotional exhaustion, compassion fatigue and burnout, and moral distress.

Environments that increase the risk for emotional exhaustion, compassion fatigue and burnout, and moral distress for perinatal nurses include: 1) the sense of duty to care and over-

commitment to the bereaved family and/or workplace; 2) negligence about self-care and stress management; 3) lack of self-awareness and the understanding of how occupational stressors affect mental and emotional wellbeing and; 4) over-exposure to death and dying, perinatal loss and bereaved families (Arbour & Wiegand, 2014; Evans, 2012; Gillett et al., 2016; Levine et al., 2017; Malloy et al., 2013; Niederriter, 2009; Nyatanga, 2012). These emotional responses are all affective responses to: 1) Intrinsic (internal) elements, i.e., lack of self-talk and self-awareness of emotional responses to providing care to bereaved families, and 2) Extrinsic (environmental) elements, i.e., lack of awareness of new and/or challenging working conditions (Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014). It is important for perinatal nurses to address these intrinsic and extrinsic elements that condition nursing practice, by means of debriefing with mentors and being guided to self-reflect, in order to regularly exercise emotional and psychological wellness, in the end-of-life care context (Jones, 2016; Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014).

Discomfort and fear of death.

Discomfort and fear of death, and the other emotional responses requires time, during the workday, for perinatal nurses to examine their attitudes and values towards bereavement care, and reflect on how they are coping with providing bereavement care (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Terry & Carroll, 2008). In addition, the emotions such as fear of death and discomfort in providing bereavement care suggests: 1) lack of knowledge, education and/or exposure to death and dying or perinatal loss and; 2) previous emotional distress from a personal or professional experience with loss (Adams, 2009, 2010; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Parry, 2011; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Florence Wald's conceptualization of palliative care and death education to promote dying with dignity recommends that care providers learn to 'know death', instead of fear it (Adams, 2009, 2010). Learning to 'know death' requires awareness and motivation to overcome emotional and psychological barriers (Adams, 2009, 2010; Evans, 2012; Vanderspank-Wright et al., 2011). Evidence suggests that mentoring is an exemplary opportunity to support individuals who are struggling to overcome their fear or discomfort with death (Adams, 2009, 2010; Evans, 2012; Kopp, 2014; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Symptoms that are associated with discomfort with death and the fear of death include anxiety, feelings of helplessness and powerlessness, lack of confidence, frustration, and apprehension (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). These symptoms are important for 1) mentors to be cognizant of, to determine ways to better support mentees and; 2) mentees to be self-aware of, to determine their level of comfort providing bereavement care (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

For those who cannot overcome their fear of death, through experiential learning, discussion and debriefing, mentoring is still of value because it 1) is a means to cultivate a compassionate mentor-mentee partnership and recognition and respect for another's limitations, which is important for supporting perinatal nurses and 2) helps mentors to identify those who are struggling, to prevent further emotional distress and reduce the risk for emotional exhaustion, moral distress and burnout (Evans, 2012; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Coping mechanisms.

Whether innate or acquired, helpful, or ineffective, coping mechanisms are a means for managing the emotional pitfalls of providing end-of-life care (Jones, 2016; Malloy et al., 2013; Parry, 2011; Ranse et al., 2012; Terry & Carroll, 2008). The less positive coping mechanisms include: abandonment, avoidance, and compartmentalization (Arbour & Wiegand, 2014; Foltz-Ramos, 2017; Lewis & Ahern, 2017; Niederriter, 2009; Terry & Carroll, 2008). Some of the more constructive coping mechanisms include: accessing peer support, setting boundaries, debriefing, taking a positive outlook, and being purposefully grateful (Foltz-Ramos, 2017; Lewis & Ahern, 2017). Because both categories of coping mechanisms indicate how nurses are managing their emotional and mental wellness in the end-of-life care context they need to be understood to promote healthy self-management and collegial support (Lewis & Ahern, 2017).

Abandonment, avoidance, and compartmentalization.

Abandonment, avoidance, and compartmentalization are common, yet complex, behaviors for nurses; they suggest that the nurse is not ready for or is struggling to develop the emotional steps deemed valuable to provide holistic, meaningful care for families experiencing a perinatal loss (Evans, 2012; Lewis & Ahern, 2017). So inevitably, perinatal nurses that face difficulty overcoming these behaviours encounter the strain of overcoming these emotionally distressing behaviours, in the end-of-life care context (Evans, 2012; Lewis & Ahern, 2017). These behaviors can be attributed to a lack of cognitive and affective preparation for and/or exposure to death, and/or previous emotional distress from personal or professional loss or negative experiences that have caused the care provider to unconsciously develop abandonment and compartmentalization behaviors as a means to adapt and cope (Terry & Carroll, 2008). These behaviours are innate or acquired coping mechanisms and/or societal learned behavior,

which are indicated by avoiding conversations around death and dying, abandoning or avoiding the patient and family during important conversations, and/or abandoning or avoiding family during the actual dying process (Foltz-Ramos, 2017; Terry & Carroll, 2008). These behaviors not only create immediate distress for the patient and family who are not receiving the care and comfort they require, but may also contribute to long-term emotional distress (including anxiety, moral distress, discomfort, and fear of death) for the perinatal nurse (Arbour & Wiegand, 2014; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008).

Nurses can be assisted to reframe death as a normal process and the workplace culture can facilitate grief expression through debriefing and peer support (Adams, 2009, 2010; Arbour & Wiegand, 2014; Foltz-Ramos, 2017). Education that encourages boundary setting, a positive outlook, and the re-conceptualization of death as something that is not to be feared, provides a foundation for cognitive restructuring that promotes healthy emotional behaviors among perinatal nurses, who are amenable to being mentored in the end-of-life care context (Adams, 2009, 2010; Lewis & Ahern, 2017).

Peer and leadership support and debriefing are ways to help nurses validate and express their emotional responses to end-of-life care events, and to promote self-reflection; a collegial presence may provide comfort and emotional support for those needing guidance and positive reinforcement (Lewis & Ahern, 2017; Malloy et al., 2013; Vanderspank-Wright et al., 2011). Comfort, emotional support, and validation for novice or expert nurses is crucial for building an institutional culture that recognizes the value of front-line care providers, and the patient and family (Vanderspank-Wright et al., 2011). Such a culture is important for improved nursing morale in an emotionally high stress environment like perinatal loss bereavement care (Vanderspank-Wright et al., 2011). Thus, to reduce abandonment, avoidance, and

compartmentalization as negative coping mechanisms in the perinatal context, education, peer support and role modelling are necessary (a form of non-abandonment behaviours), to promote healthy nursing emotional development and nurse-family engagement (Arbour & Wiegand, 2014; Terry & Carroll, 2008).

Emotional labor and emotional intelligence.

Emotional labor.

To cope with providing end-of-life care, perinatal nurses often emotionally remove themselves from patient care situations by using behaviors like avoidance, abandonment, and compartmentalization, so as to protect themselves from emotional turmoil (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). Such behaviors signify lack of emotional labor. Emotional labor is meant to support nurses to display engagement and social interaction with patients and their families (Evans, 2012; King-Okoye & Arber, 2014; Lewis & Ahern, 2017). The demonstration of emotional labor includes the use of empathy, presence, and touch (if culturally and individually acceptable), and active-listening and silence, while providing meaningful bereavement care, which is holistic care, individualized to the grieving patient and family (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). Emotional labor is experientially learned through collegial support or mentoring, and it is the first part of a two-part emotional development journey to become an emotionally intelligent perinatal nurse (King-Okoye & Arber, 2014; Lewis & Ahern, 2017).

Emotional intelligence.

The developmental road to emotional intelligence is a step-by-step process that can only be achieved once emotional labor is effortlessly mastered (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). Emotional labor can be differentiated from emotional

intelligence, which requires one to manage one's own emotions in providing dignified end-of-life care. Emotional labor only requires nurses to emphasize communication and presence in the nurse-patient/family relationship, without considering how to manage their emotions in the process (Adams, 2009, 2010; Arbour & Wiegand, 2014; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Ranse et al., 2012). The process of emotional intelligence builds on emotional labor which starts with nursing presence, empathy, active-listening and silence, to using self-reflection to manage one's emotions while providing end-of-life care (Evans, 2012; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). In learning how to manage one's emotions, peer support, role modelling, and debriefing are vital parts of the experiential, educational pathway to emotional intelligence (Adams, 2009, 2010; Arbour & Wiegand, 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Murakami et al., 2015; Nyatanga, 2012; Terry & Carroll, 2008). Debriefing and discussion are meant to help the novice nurse work through the emotional responses to experiential end-of-life care encounters; guidance from a role model, the expert nurse or mentor facilitates the process (Adams, 2009, 2010; Arbour & Wiegand, 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Murakami et al., 2015; Nyatanga, 2012; Terry & Carroll, 2008).

Using expert nursing presence and collaboration during debriefing, nurses learn to work through their emotions, via self-reflection to enhance their emotional labor and emotional intelligence (Adams, 2009, 2010; Arbour & Wiegand, 2014; Evans, 2012; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008). This point is important because un-addressed emotional stressors and coping mechanisms have implications for the care provider's emotions

and ability to evolve from a novice to expert nurse (Adams, 2009, 2010; Arbour & Wiegand, 2014; Evans, 2012; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008). By developing emotional labor and intelligence, perinatal nurses would be able to: 1) promote quality end-of-life care for bereaved families, and 2) mitigate perinatal loss related stressors (Adams, 2009, 2010; Arbour & Wiegand, 2014; Evans, 2012; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008).

To promote high quality end-of-life care in perinatal nursing, including attending to emotional stressors and conceptualizations of death, coping mechanisms and emotional labor and emotional intelligence, processes need to be examined for their support and education of perinatal nurses providing bereavement care.

Grief counselling and bereavement support.

The emotionally exhaustive demands associated with providing end-of-life care in the perinatal context illustrate the need for emotional and psychological support for nurses to manage their own grief and provide bereavement support for others (Adams, 2009, 2010; Arbour & Wiegand, 2014; Evans, 2012; Gillett et al., 2016; Hartley, 2011; Howe & Scott, 2012; Horey et al., 2015; Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Murakami et al., 2015; Nyatanga, 2012; Olausson & Ferrell, 2013; Pye, 2016; Ranse et al., 2012; Steven et al., 2014; Vanderspank-Wright et al., 2011). My synthesis points to the need for nurses to first learn ways to manage their own grief so that they are able to provide individualized bereavement support for patients and families (Arbour & Wiegand, 2014; Evans, 2012; Gillett et al., 2016; Horey et al., 2015; Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013;

Murakami et al., 2015; Nyatanga, 2012; Pye, 2016; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Vanderspank-Wright et al., 2011). In addition, the way in which emotional and bereavement support shapes nursing and the quality of patient care needs to be understood.

Grief support for nurses.

Nurses providing bereavement support for grieving families inevitably encounter feelings of grief and loss, due to the simple experience of being front-line care providers for bereaved families (Evans, 2012; Nyatanga, 2012; Pye, 2016; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). However, nurses' lack of previous exposure to death, education about death, or burnout may exacerbate the overall emotional experience for a nurse, and contribute to the anxiety and emotional turmoil of providing end-of-life care (Arbour & Wiegand, 2014; Evans, 2012; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Niederriter, 2009; Nyatanga, 2009; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Thus, access to grief support is important, in order to help perinatal nurses to learn to improve their coping mechanisms and determine any unresolved grief, which would otherwise affect the quality of patient care and quality of life and job satisfaction for perinatal nurses, in the bereavement care context (Arbour & Wiegand, 2014; Evans, 2012; Foltz-Ramos, 2017; Nyatanga, 2012; Pye, 2016).

Grief counselling and emotional support by allied health and leadership for novice perinatal nurses is needed to promote a positive working environment for perinatal nurses (Arbour & Wiegand, 2014; Evans, 2012; Horey et al., 2015; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Olausson & Ferrell, 2013; Ranse et al., 2012; Vanderspank-Wright et al., 2011). Formal and informal grief counselling between novice perinatal nurses and spiritual care, social work, counsellors, clinical nurse educators and/or clinical nurse specialists, in the

form of workshops and one-to-one nursing support, appeared in the literature review, supporting the benefits for the emotional and mental wellness of nurses in end-of-life care contexts (Arbour & Wiegand, 2014; Evans, 2012; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Ranse et al., 2012).

At the same time, peer support occurs through an experiential process that involves the shared expression of emotions using real-life experiences for individuals to reflect and gain self-awareness and work through the grief and emotional turmoil experienced in the workplace (Arbour & Wiegand, 2014; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Lavoie, Blondeau & Martineau, 2013; Lewis & Ahern, 2017; Steven et al., 2014; Vanderspank-Wright et al., 2011). Peer support can be used: 1) formally, in a workshop style setting or; 2) informally, on an as needed basis in a clinical setting, as a means for nurses to collaboratively work together to address grief and learn to cope with death (Arbour & Wiegand, 2014; Horey et al., 2015; Jones, 2016; Lewis & Ahern, 2017; Parry, 2011; Ranse et al., 2012; Steven et al., 2014; Vanderspank-Wright et al., 2011).

Both peer support and grief counselling are essential for promoting healthy coping mechanisms that consider intrinsic ways (self-awareness and reflection) to positively influence extrinsic (patient and family care) experiences (Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Steven et al., 2014). To help perinatal nurses overcome the emotional barriers in end-of-life care, access to education on grief, in a didactic setting and simulated or hands-on experiential training on communication skills and coping mechanisms are necessary, for empowering perinatal nurses to be confident and comfortable in providing quality end-of-life care (Evans, 2012; Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al.,

2013; Murakami et al., 2015; Nyatanga, 2012; Steven et al., 2014; Vanderspank-Wright et al., 2011).

Nurses providing bereavement support.

My synthesis generated an overarching theme, which is the need to support nurses with access to communication tools and support from social workers and spiritual advisors, to develop bereavement counselling skills, and thus, improve their confidence and comfort in fulfilling their roles as perinatal nurses to support bereaved parents and families (Adams, 2010; Arbour & Wiegand, 2014; Crawford et al., 2013; Evans, 2012; Foltz-Ramos, 2017; Horey et al., 2015; Malloy et al., 2013; Murakami et al., 2015; Pitman, 2013; Pye, 2016; Steven et al., 2014; Virani et al., 2014). Bereavement support is recognized as an element of end-of-life care, and so, in order to facilitate a positive bereavement experience for patients and families, nurses must: 1) be cognizant, through self-reflection, of emotional, psychological, spiritual and cultural domains and how each affects the patient and family experiencing a perinatal loss; 2) integrate a holistic, individualized approach to care, exhibiting nursing presence, active listening, empathy and compassion, as a part of a communication toolkit for bereavement support; and 3) self-reflect on their perceptions about death and dying and how it affects their nursing practice (Adams, 2009, 2010; Crawford et al., 2013; Evans, 2012; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Murakami et al., 2015; Pye, 2016; Steven et al., 2014; Temkin-Greener et al., 2009).

Empirical findings suggest a need to generate specialty-specific bereavement counselling, to promote understanding of theory to practice bereavement support in the perinatal context, by means of: 1) didactic education on provision of grief support for bereaved families and 2) experiential learning, with mentor support, of how bereavement counselling is effectively

executed in practice (Pye, 2016). Valuable components that shape bereavement counselling that perinatal nurses provide include: empathy and nursing presence; their integration produces a lasting effect on the emotional recovery and psychological wellbeing of patients and their families (Crawford et al., 2013; Evans, 2012; Ferrell et al., 2010; Kopp, 2014; Murakami et al., 2015; Pye, 2016; Steven et al., 2014). The way in which death is conceptualized by nurses, whether a nurse is comfortable with providing end-of-life care or not, is revealed by: 1) body language 2) communication with patients and families and 3) how frequently the nurse initiates nursing presence; these factors are invaluable in helping mentors determine mentee comfort with and confidence in providing bereavement counselling, especially if the learner is struggling to express their feelings towards being bereavement care providers (Adams, 2009, 2010; Arbour & Wiegand, 2014; Crawford et al., 2013; Lewis & Ahern, 2017; Murakami et al., 2015).

End-of-life care communication skills.

For nurses, patients, and families, the end-of-life care context is emotionally charged, because it centers on individualized care for the parents and family experiencing a loss (Evans, 2012; King-Okoye & Arber, 2014; Kopp, 2014; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014). Individualizing end-of-life care entails listening to the needs and wishes of the parents and families experiencing a loss, by asking open ended questions, active listening and being present during important discussions (Ramasamy Venkatasalu et al., 2015; Stevens et al., 2014). Consequently, the end-of-life care context should be established around the communication that occurs between the nurse and the patient and family and the nurse and the healthcare team, verbally and in written format, in order to facilitate adequate and time-sensitive communication among the team members. This will result in a meaningful and individualized bereavement care experience for the patient and family (Ayed et al., 2015; Crawford et al., 2013; Doucette et al.,

2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney, O'Sullivan & McCarthy, 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014).

My synthesis of the literature suggests that a lack of attention, resulting in a lack of education for nurses to promote communication skill development in the end-of-life care context, can have a domino-effect on the patient and family experience and for the nursing team members (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014). This domino-effect suggests the need to probe deeper and to determine what communication means in end-of-life care. To gain a better understanding of the causal effects for perinatal nurses and bereaved patients and families, it is important to examine the: 1) domains affected by end-of-life communication; 2) characteristics of effective communication and; 3) the impact of effective communication on the patient, the family and nursing.

The domains affected by end-of-life communication.

Effective communication is an essential element for exemplary end-of-life care in the perinatal context. It is considered to be: 1) a determinant of quality end-of-life care for the

patient and family; 2) crucial for facilitating family involvement in end-of-life decision making; and 3) a means to promote positive nursing coping mechanisms, nursing morale, and job satisfaction (Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Effective communication characteristics.

Effective communication strategies entail: 1) open and frequent dialogue, along with active listening and open-ended questions and 2) non-verbal communication, through nursing presence, warmth, sensitivity, silence and touch, in accordance with cultural norms for the patient and family (Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Kataoka-Yahiro et al., 2017; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011). Such characteristics of effective communication create an empathetic, compassionate, respectful, dignified and individualized bereavement experience, and are notable characteristics for meeting patient and family needs (Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Kataoka-Yahiro et al., 2017; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011).

Effective communication and the patient and family.

Effective communication helps bereaved parents and families avoid feelings of neglect, powerlessness, helplessness, and fear, as they grieve and go through the experience of birthing their deceased babies (Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011). Nursing experience with and use of communication skills will likely influence how parents and families cope with their grief, which emphasizes the significance of nurses' didactic learning and experiential observations of ways to be an effective and individualized communicator (Niederriter, 2009). By using effective communication skills, nurses can contribute to a positive, individualized bereavement experience for parents and families, even though they are suffering a tragic life event (Ramasamy Venkatasalu et al., 2015; Steven et al., 2014).

The involvement of parents and families in end-of-life care decision-making processes in after death rituals and wishes, such as: 1) identifying when to view the baby 2) cutting the cord 3) baby hand and foot prints 4) pictures with the baby, 5) determining how much time the family would like with the baby, and 6) determining if the baby will room in with the family or not, can foster positive bereavement memories for the family (Adams, 2009, 2010; Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Hales & Hawryluck, 2008; Kataoka-Yahiro et al., 2017; Kopp, 2014; Murakami et al., 2015; Olausson & Ferrell, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Steven et al., 2014; Vanderspank-Wright et al., 2011). Relationship building and effective communication, by active listening and nursing presence, is also important in the end-of-life care decision-making process to advocate for and support individuals and/or families who do not want mementos

and/or prolonged time with their baby (Evans, 2012; Foltz-Ramos, 2017; Olausson & Ferrell, 2013; Pye, 2016). Patient and family involvement and advocacy, in the end-of-life decision-making process are important for promoting a dignified, meaningful, and respectful experience for bereaved parents and families, and so, they are important elements to consider in mentoring, to cultivate effective communication skills (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Kopp, 2014; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Pye, 2016; Steven et al., 2014; Vanderspank-Wright et al., 2011).

Effective communication and nursing education.

The use of effective communication skills, such as the characteristics previously discussed, can further support nurses to handle complex scenarios surrounding death and dying, such as: 'breaking bad news', discussing difficult topics, handling strong emotions, and tackling difficult questions without using ineffective emotional coping mechanisms that are anxiety-provoking or related to avoidance (Crawford et al., 2013; Ferrell et al., 2010; Gillett et al., 2016; Nyatanga, 2012; King-Okoye & Arber, 2014; Sweeney et al., 2015). 'Breaking bad news' and handling difficult questions are tasks for most nurses that tend to provoke negative emotional and psychological reactions in: 1) novice nurses without education about effective communication and how to handle these types of scenarios, and 2) patients and families who may receive information from the care providers in ways that may have a lasting negative effect (Crawford et al., 2013; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011).

Therefore, communication is both a key determinant of the emotional and mental health of patients and families and an influence on the emotional and mental capacity of perinatal

nurses and their willingness to continue caring for bereaved families experiencing a perinatal loss (Crawford et al., 2013; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). A clear need exists for education and awareness about effective communication characteristics, in a didactic setting, and thus, implemented by mentors, and observed and comprehended by mentees, in an experiential setting (Crawford et al., 2013; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Sweeney et al., 2015).

Empirical findings suggest there is a notable disconnection between the frequency of communication skill theory taught and the frequency of effective communication skills used, by nurses in end-of-life care settings (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; King-Okoye & Arber, 2014; Kopp, 2014; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014). Despite theoretical evidence of communication skills dialogue, a significant amount of evidence suggests that in practice, effective communication is lacking, and nurses are continuing to exhibit low confidence in their ability to communicate with bereaved patients and families (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; King-Okoye & Arber, 2014; Kopp, 2014; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014). Approaches to improving communication are available, especially around end-of-life care communication. There are resources for perinatal nurses to improve their support for bereaved parents and families. Improved support promotes a

positive environment for: 1) the patient and family, by tailoring care to the needs of individual families; 2) nurses, through self-reflection and awareness about communication abilities and emotions; and 3) colleagues, through role modelling, debriefing, supporting, and mentoring others in using effective communication skills during the care of families experiencing a perinatal loss (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014). Therefore, to reiterate, individualized care, self-reflection and self-awareness of nurses' communication abilities and emotions, role modelling, debriefing, peer support and mentoring are all important for an effective communication enhancement approach, in the end-of-life care context (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014).

All of the variables for communication in end-of-life care are inter-connected and influence the nurse, patient, and family, which suggests the need for actual experience, through experiential communication strategies, in partnership with mentors who can support perinatal

nurses to become effective communicators in complex end-of-life care settings (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Reflection and debriefing.

Reflection (dialogue with oneself) and debriefing (dialogue with another) are used to cope with complex emotional responses to death and dying. When these activities are absent, the development of negative nursing coping mechanisms can result, with negative effects on the quality of end-of-life care for bereaved families (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lavoie et al, 2013; Lewis & Ahern, 2017; Malloy et al., 2013; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). To determine how to overcome the nursing challenges associated with perinatal bereavement care, the subject needs to be probed to understand the links between reflection, debriefing, and perinatal nursing care in the end-of-life care context.

Reflective practice.

In my synthesis of the literature, I identified reflection as a critical practice for nurses to manage emotions in the end-of-life care nursing context. Reflection serves to promote: 1) a deeper learning, which provides an opportunity to identify one's strengths and weaknesses, while using critical thinking skills; and 2) the development of positive coping mechanisms, through

self-awareness and recognition of one's emotional reactions to grief and loss (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Kopp, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011).

The cognitive and affective domains of reflective practice can help nurses understand, critically analyse, and gain self-awareness of their own emotions to promote their emotional and psychological health (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Kopp, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011). The process is especially significant for perinatal nurses who are providing care for bereaved parents and families due to their emotional exhaustion and grief (Arbour & Wiegand, 2014; Ayed et al., 2015; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Nyatanga, 2012; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Reflective practice can include: 1) self-reflection, using writing and/or self-talk after an experiential encounter; and 2) facilitated reflection, which is probed by peers or mentors (Crawford et al., 2013; Doucette et al., 2014; Gillett et al., 2016; Kopp, 2014; Malloy et al., 2013).

Reflective practice and emotional intelligence.

Reflective practice is used to consolidate learning and empower nurses to confront the emotional bereavement care challenges they encounter, such as moral distress, emotional and physical exhaustion from role advocacy and over-commitment, anger, guilt, personal anxieties, and dealing with their grief (Arbour & Wiegand, 2014; Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Nyatanga,

2012; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Ultimately, reflection is crucial for the development of one's emotional labour and emotional intelligence, emotional stamina, and self-awareness; it offers an opportunity to explore and improve one's emotional and psychological wellbeing (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Reflective practice and communication.

Reflection is also used to improve communication with bereaved parents and families, by reflecting on one's attitudes, values, and beliefs about perinatal loss, death and the bereavement journey, and understanding how these viewpoints can influence the grief and loss of a bereaved family (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011). This form of reflective practice is necessary to become a more empathetic, compassionate, and intuitive perinatal nurse, resulting in communication skills relevant to patient and family needs with positive implications for the quality of care (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011).

Reflection and fostering a positive health care environment.

Reflective practice is a nursing skill and coping mechanism that can help perinatal nurses navigate the emotional and psychological distress experienced when caring for bereaved families (Arbour & Wiegand, 2014; Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Nyatanga, 2012; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). The technique may also positively affect self-care, communication skills, and emotional intelligence

(Arbour & Wiegand, 2014; Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Nyatanga, 2012; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Thus, reflective practice is a factor that contributes to a positive working environment for perinatal nurses, and is an indicator of the quality of end-of-life care provided (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lavoie et al, 2013; Lewis & Ahern, 2017; Malloy et al., 2013; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Debriefing.

Debriefing is a form of reflection, through dialogue with another individual, while providing end-of-life care to bereaved families (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). The practice occurs in partnership with someone who can relate to nurses' experiences, like a peer, mentor, nursing leader, or allied health professional (i.e., social work) (Doucette et al., 2014; Lewis & Ahern, 2017; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Debriefing requires engaging in dialogue and learning to work through emotional responses to the experiences encountered (Doucette et al., 2014; Lewis & Ahern, 2017; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Debriefing is recognized as a valuable and healthy method of coping with grief, because it offers an opportunity for perinatal nurses to: 1) voice fears, concerns, reactions, emotions, and feelings; 2) build emotional stamina by expression of feelings; and 3) receive feedback and gain insight on how to move forward in practice (Doucette et al., 2014; Gillett et al., 2016; King-

Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Debriefing is intended to help perinatal nurses, who may be struggling to self-reflect, and to gain insight and self-awareness, and thus, the ability to reflect. It creates opportunities for positive reinforcement from peers and mentors, by promoting a positive nursing environment and mindset for mentors and mentees, and reducing the risk for burnout (Crawford et al., 2013; Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lavoie et al., 2013; Lewis & Ahern, 2017; Malloy et al., 2013; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Debriefing is, thus, crucial to regain emotional and cognitive clarity and establish partnerships with team members, for a more positive workplace experience (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Cultivating a debriefing culture.

A standardized debriefing practice could create a positive health care climate for perinatal nurses, assist them to find meaning in their discipline, and promote quality in the end-of-life care experienced by bereaved families (Gillett et al., 2016; Ranse et al., 2012; Terry & Carroll, 2008).

To promote quality care for bereaved parents and families, the bereavement needs of perinatal nurses should be addressed by regular debriefing with peers and mentors; permitting consistency in debriefing, like in a structured mentorship program, can cultivate a debriefing culture (Doucette et al., 2014; Gillett et al., 2016; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Collaborative learning and decision making.

End-of-life care is a complex and emotionally charged experience for bereaved parents (Evans, 2012; Pye, 2016). To better support bereaved patients and families, it is critical to consider their physical needs (i.e., pain management) and spiritual (i.e., access to spiritual support), emotional (i.e., how they are coping), psychosocial (i.e., financial, housing, support system) and cultural (i.e., touch, proximity, cultural rituals) needs and wishes, using a collaborative learning and decision-making approach (Adams, 2009, 2010; Drenth et al., 2018; Niederriter, 2009). Collaborative learning and decision-making entails: 1) participation, insight and voice from patients and families and; 2) knowledge, expertise and partnership, with multi-disciplinary team members and nursing leadership (Adams, 2009, 2010; Drenth et al., 2018; Niederriter, 2009). Collaborative learning and decision making is a collective approach for perinatal nursing bereavement practice, which translates through: 1) mentoring and debriefing, for nurses and 2) patient and family involvement and advocacy, during the end-of-life decision-making processes (Adams, 2009, 2010; Arbour & Wiegand, 2014; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Hales & Hawryluck, 2008; Hartley, 2011; Horey et al., 2015; Jones, 2016; Mahler, 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013; Quinn & Hudson, 2014; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Collaborative learning, decision making, and the nurse.

Collaborative learning and decision making among perinatal nurses is a process that involves nursing partnership, co-operation, team work, respect and effective communication skills and is visible and established in mentoring, debriefing and peer support interactions (Adams, 2009, 2010; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hales &

Hawryluck, 2008; Hartley, 2011; Horey et al., 2015; Jones, 2016; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Quinn & Hudson, 2014; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). Collaborative learning and decision making provides opportunities for nurses to support holistic end-of-life care to bereaved families, through multi-disciplinary and collaborative approaches with other members of the team (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011). Collaborative learning and decision making is a means for nursing to create a culture that: 1) promotes communication and clarity among all team members and patients and families; 2) empowers nurses to address emotional stressors and improve coping mechanisms for optimal self-care and; 3) enables nursing team members to participate in and cultivate best practice guidelines, in the end-of-life care context (Adams, 2009, 2010; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Hartley, 2011; Horey et al., 2015; Jones, 2016; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Quinn & Hudson, 2014; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Team work and multi-disciplinary partnerships, integrative learning, with linkages with processes in end-of-life care, and effective communication skills and respect are necessary components for perinatal nurses to become collaborative decision makers, in the perinatal bereavement care context (Adams, 2009, 2010; Doucette et al., 2014; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Mahler, 2010; Niederriter, 2009; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Mentoring.

For nurses who may be struggling to provide bereavement care to patients and families, a collaborative learning and decision-making philosophy can contribute to a supportive environment for patients, families, and nurses, through mentoring and debriefing among the nursing team members (Adams, 2009, 2010; Evans, 2012; Hartley, 2011; Jones, 2016; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

It is important to create a culture of collaborative learning and decision making by cultivating partnerships, team building, and teaching and learning skills among nursing team members; these activities will support perinatal nurses to become mentors (Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hartley, 2011; Horey et al., 2015; Jones, 2016; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). When mentors help mentees (or novice nurses), perinatal nurses can navigate the challenges associated with bereavement care, and increase their understanding of perinatal bereavement, resulting in quality care for families experiencing a perinatal loss (Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Hartley, 2011; Haugan & Hanssen, 2012; Horey et al., 2015; Murakami et al., 2015; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Mentoring and debriefing among nurses also have a ‘trickle-down effect’ on the nurse-patient/family relationship, because mentoring and guiding can improve nursing communication skills, and develop perinatal nursing emotional intelligence and helpful coping mechanisms (Doucette et al., 2014; Evans, 2012; Hartley, 2011; Mahler, 2010; Murakami et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). These features, mentoring and debriefing,

of collaborative learning and decision making promote knowledge, comfort, confidence, collegial support, and communication skills; all of these are helpful coping mechanisms for nurses who are learning to support bereaved patients and families (Doucette et al., 2014; Evans, 2012; Hales & Hawryluck, 2008; Hartley, 2011; Horey et al., 2015; Jones, 2016; Mahler, 2010; Murakami et al., 2015; Pye, 2016; Quinn & Hudson, 2014; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Mentoring, as an approach to collaborative learning and decision making, is crucial for developing nursing competency, self-care, communication skills, team building, nursing morale, trust among nursing team members and multi-disciplinary relations, and quality of bereavement care for parents and families (Doucette et al., 2014; Evans, 2012; Hartley, 2011; Haugan & Hanssen, 2012; Horey et al., 2015; Jones, 2016; Mahler, 2010; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Culture of collaboration.

By creating a mentoring environment that promotes collaborative learning and decision making in the perinatal bereavement context, an opportunity is created for a culture change for perinatal nurses working in other areas, such as labor and delivery, postpartum and antepartum (Doucette et al., 2014; Drenth et al., 2018; Hartley, 2011; Virani et al., 2014). Mentors' and mentees' collaborative learning and decision making promotes team work, inter-disciplinary collaboration, confidence in leadership abilities, and team-building, for all nurses, including those situated in environments with poor nursing morale (Adams, 2009, 2010; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Hartley, 2011; Horey et al., 2015; Jones, 2016; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Quinn &

Hudson, 2014; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Collaborative learning, decision making, and the patient and family.

The experience of losing a child is life-altering for parents and families and, similarly to any other bereavement and death experience, creates a risk for powerlessness among the parents and families, who are not involved in the decision making for their end-of-life care experience (Adams, 2009, 2010; Evans, 2012; Hales & Hawryluck, 2008; Murakami et al., 2015; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011).

Florence Wald, a nursing leader, first supported the notion of involving patients and families in decision-making processes to better understand how to provide dignified and individualized care for families experiencing a loss (Adams, 2009, 2010). A lack of patient and family collaboration or involvement in the end-of-life care decisions is a barrier to providing quality care to bereaved parents and families, which ultimately has a negative effect on nursing job satisfaction and morale (Adams, 2009, 2010; Evans, 2012; Hales & Hawryluck, 2008; Hartley, 2011; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012). Therefore, to promote a positive bereavement experience for families and nurses, perinatal nurses need to include, hear, and receive input about decision-making from patients and family members during and after the perinatal loss experience, in the end-of-life perinatal bereavement context (Adams, 2009, 2010; Evans, 2012; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012).

Collaborative learning and decision making, involving the parents and families, is also an opportunity for understanding cultural, religious, social, and individualized family-specific wishes in the end-of-life care context (Adams, 2009, 2010; Hales & Hawryluck, 2008; Horey et al., 2015; Murakami et al., 2015; Ramasamy Venkatasalu et al., 2015). Furthermore,

collaborating with families is a chance for families to receive answers to any looming questions they may have about the death process, and to allow nurses to assess their emotional and psychological needs that could otherwise be overlooked (Adams, 2009, 2010; Murakami et al., 2015; Ranse et al., 2012). When collaborative learning and decision making involves families, it can promote a more holistic, individualized model of end-of-life care for bereaved parents and families and contribute to a positive bereavement experience for families and perinatal nurses (Adams, 2009, 2010; Murakami et al., 2015; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012).

Patient and family advocacy.

Patient and family involvement in the end-of-life care decisions is enabled through patient and family advocacy (Arbour & Wiegand, 2014; Doucette et al., 2014; Ferrell et al., 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013). Patient and family advocacy is necessary to ensure patient and family wishes and needs are met, and to cultivate a meaningful bereavement experience for the patient and family (Arbour & Wiegand, 2014; Doucette et al., 2014; Ferrell et al., 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013). This process is implemented by: 1) providing care from the patient and family-centered focus 2) promoting the family's presence in decision making processes and 3) ensuring that the wishes (including cultural or religious) of the patient and family are addressed (Arbour & Wiegand, 2014; Doucette et al., 2014; Ferrell et al., 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013).

To facilitate the involvement of the patient and family in the end-of-life care decisions, the perinatal nurse needs to be present to educate the patient and family on bereavement care processes, and initiate difficult discussions using empathy, compassion, and active listening

(Arbour & Wiegand, 2014; Doucette et al., 2014; Ferrell et al., 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013).

Nurses can be leaders in patient and family advocacy. Advocacy is positively correlated with nursing job satisfaction and role expression (Arbour & Wiegand, 2014; Doucette et al., 2014; Ferrell et al., 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013). Perinatal nurses need to have access to adequate self-care and communication tools and education and experiential training for patient and family advocacy and collaborative decision-making, which are indicators of the quality of end-of-life care for bereaved families.

Collaborative learning and decision making are significant for creating a positive bereavement experience for all individuals involved in the care of a family experiencing perinatal loss (Adams, 2009, 2010; Arbour & Wiegand, 2014; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Hales & Hawryluck, 2008; Hartley, 2011; Horey et al., 2015; Jones, 2016; Mahler, 2010; Malloy et al., 2013; Murakami et al., 2015; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Quinn & Hudson, 2014; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Didactic and experiential learning.

For nurses in the end-of-life care context, both didactic and experiential learning are needed to ensure that seasoned and novice nurses are supported in this care environment (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Death

education in the end-of-life care context tends to be routinely didactic, instead of being experiential or a mixture of both kinds of learning (Arbour & Wiegand, 2014). To prepare perinatal nurses with non-technical skills like communication with bereaved families, self-care, development of emotional intelligence, debriefing, patient and family advocacy, and self-reflection, a combination of didactic and experiential learning is necessary (Arbour & Wiegand, 2014; Doucette et al., 2014; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015).

Because the end-of-life care context can provide an emotionally exhausting experience, nurses must have a thorough understanding of perinatal loss theory and practice, through didactic, or theoretical knowledge on perinatal loss and experiential learning, or clinical or simulated experience (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Both approaches are crucial because didactic learning helps to develop a theoretical knowledge foundation about perinatal loss and experiential learning allows nurses to observe, ask questions, apply theory, debrief and reflect, and inevitably, promote theoretical knowledge transfer through clinical or simulated experiences (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011).

Despite the utility of didactic learning for building a theoretical foundation for learning about perinatal loss, it is insufficient to promote knowledge transfer, to help nurses develop coping and self-care mechanisms, or to practice ways of communicating with families (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Experiential learning, through clinical or simulated experiences, is mandatory in the perinatal loss bereavement care context; it requires support from peers or mentors (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Blended didactic and experiential learning approaches can facilitate the initial and ongoing education for nurses, and promote a culture of learning, interdisciplinary collaboration, respectful communication, team building, and support for nurses when managing their grief and emotions (Arbour & Wiegand, 2014; Doucette et al., 2014; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015).

Simulation.

Although mentoring is idealized as a means for implementing experiential learning, many scenarios exist where a lack of clinical time prevents hands-on learning. Thus, simulation or role play could be used as an alternative (Crawford et al., 2013; Foltz-Ramos, 2017; Gillett et al.,

2016; Kopp, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Simulation allows for seasoned and novice nurses to learn or revise their technical and non-technical nursing skills for end-of-life care, in a controlled and scenario-specific environment (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Simulation allows nurses to ask questions, observe, reflect, debrief, and receive feedback on different end-of-life care scenarios, and prepare valuable skills for nursing practice (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Active and interactive simulation, with opportunities for feedback and discussion, is beneficial for learning how to communicate and handle end-of-life care scenarios (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Lewis & Ahern, 2017; Pye, 2016; Sweeney et al., 2015). Active participation and interactions with mentors and leadership in simulation scenarios can be used to assess learners' comfort and confidence to prepare them for nursing practice (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011).

Although simulation is a suitable alternative to environments that lack access to clinical encounters, real interactions with bereaved families experiencing a perinatal loss, with guidance from a mentor, are the most effective means for developing technical and non-technical skills for providing care to this population (Gillett et al., 2016; King-Okoye & Arber, 2014; Steven et al., 2014; Vanderspank-Wright et al., 2011). The mentor has a highly valued and influential role for experiential encounters, because he or she provides the learner with one-to-one support, and addresses any gaps in the learner's technical, emotional, psychological, or cognitive abilities as a bereavement care provider (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al.,

2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). The mentor's role is to improve the learner's comfort and confidence; while mentoring is typically implemented for clinical experiences, it can also be used in simulations (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Haugan & Hanssen, 2012; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011).

Summary

My synthesis of the literature supports four overarching themes: 1) end-of-life care and nursing, 2) emotional stressors and conceptualizations of death, 3) coping mechanisms, and 4) emotional labor and emotional intelligence. Five processes were identified: 1) grief counselling and bereavement support, 2) end-of-life care communication skills, 3) reflection and debriefing, 4) collaborative learning and decision making, and 5) didactic and experiential learning. The themes and processes endorse the need for support and education for seasoned and novice nurses in the end-of-life care context. They are also highly applicable to the perinatal bereavement care setting. Based on the literature review, I have incorporated the components and structure in a perinatal loss mentorship program.

Chapter 4: Components and Structure for a Perinatal Loss Mentorship Program

Chapter four describes the components and structure needed for a perinatal loss mentorship program, to better support and educate perinatal nurses about perinatal loss. From a review of the literature, I will describe the components and structure needed to address the research question. In particular, the all-encompassing and predominant components mentioned in the literature review are didactic and experiential learning, which come together to form blended learning (Arbour & Wiegand, 2014; Doucette et al., 2014; Howe & Scott, 2012; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). This chapter divides didactic and experiential learning into two central structures, in conjunction with several other significant components. Before delving into the details for the relevant components, I will examine the theoretical groundwork and components needed to construct bereavement knowledge for perinatal nurses.

Didactic Learning

The literature review supports blended learning for promoting knowledge transfer and facilitating positive attitudes among nurses, because it is meant to gradually link theory and practice and address the complex emotions associated with providing end-of-life care (Arbour & Wiegand, 2014; Doucette et al., 2014; Howe & Scott, 2012; Jones, 2016; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Sweeney et al., 2015). Didactic learning forms the first part of blended learning that entails information-focused learning in a traditional learning environment (Arbour & Wiegand, 2014; Kopp, 2014; Koren et al., 2008; Olausson & Ferrell, 2013; Pye, 2016).

A major element of promoting effective knowledge transfer in a didactic learning environment, is interactive, workshop-style learning (Crawford et al., 2013; Doucette et al., 2014; Ferrell et al., 2010; Hales & Hawryluck, 2008; Kataoka-Yahiro et al., 2017). Interactive, workshop-style learning supports learning as a dynamic and collaborative learning experience. Guidance comes in the form of reflection and debriefing with peers and mentors, which helps to address nursing confidence and comfort-related questions, thus, leading to the promotion of knowledge transfer (Crawford et al., 2013; Doucette et al., 2014; Ferrell et al., 2010; Hales & Hawryluck, 2008; Kataoka-Yahiro et al., 2017; Kopp, 2014). Interactive, workshop-style learning is especially beneficial for novice perinatal nurses requiring time to reflect, discuss, and debrief with mentors about new and challenging conversations and themes in end-of-life care (Hales & Hawryluck, 2008).

An interactive, workshop-style learning structure is needed to create a profound learning experience for perinatal nurses, which includes the following content components: 1) theoretical foundations of grief in the perinatal context, 2) holistic, individualized perinatal bereavement care, 3) mentoring, with reflection and debriefing, 4) nursing self-care with self-awareness and coping mechanisms, 5) nursing grief support and counselling, and 6) communication skills. Overall, these six components are frequently indicated in the literature review. To determine their place in a perinatal loss mentorship program, each component needs to be described with regards to the perinatal loss bereavement care context.

Theoretical foundations of grief in the perinatal context.

For perinatal nurses to be comfortable and confident with perinatal loss and to better understand the needs and wishes of grieving families, they must understand how grief is situated in the perinatal bereavement care context (Adams, 2009, 2010; Arbour & Wiegand, 2014; Kopp,

2014; Mahler, 2010; Malloy et al., 2013; Niederriter, 2009; Ranse et al., 2012; Virani et al., 2014). Nurses need to be familiar with: 1) anticipatory and un-anticipatory grief – the underpinnings and contexts associated with perinatal grief, and 2) holistic, individualized perinatal bereavement care – the process of making bereavement experiences meaningful for families (Drenth et al., 2018; Hutti, 2015; Kopp, 2014; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy-Venkatasalu et al., 2015; Ranse et al., 2012).

Anticipatory and un-anticipatory grief.

Both anticipatory and un-anticipatory grief are relevant to the perinatal specialty (Evans, 2012; Niederriter, 2009). Anticipatory grief occurs before the concrete loss of losing a loved one (Niederriter, 2009), which is familiar to those in the perinatal setting. Many families begin their grieving journey before the delivery of their baby, as seen in expected miscarriage, intra-uterine fetal demise, and/or maternal or fetal abnormalities leading to perinatal loss (Evans, 2012; Murakami et al., 2015). Meanwhile, un-anticipatory grief occurs with an unexpected loss, such as in a miscarriage or stillbirth (Evans, 2012). Whether or not the grief is expected, perinatal nurses need to recognize both forms of perinatal grief to: 1) appropriately use their communication skills for providing compassionate and meaningful bereavement care, and 2) gain comfort and confidence in handling the different emotional grief responses exhibited by a bereaved family (Arbour & Wiegand, 2014; Evans, 2012; Kopp, 2014; Mahler, 2010; Malloy et al., 2013; Niederriter, 2009; Ranse et al., 2012; Virani et al., 2014).

To prepare perinatal nurses for dealing with grief in the perinatal context, they need to be familiarized with the various scenarios of anticipatory and un-anticipatory perinatal grief, and grief from a bereaved family's perspective (Evans, 2012; Foltz-Ramos, 2017; Niederriter, 2009). Giving context to the various causes of perinatal grief can help perinatal nurses prepare for the

emotional challenges they will likely encounter (Evans, 2012). Therefore, a theoretical basis and the context of perinatal loss scenarios with perinatal grief can prepare perinatal nurses with the foundation to create meaningful experiences for bereaved families (Adams, 2009, 2010; Arbour & Wiegand, 2014; Doucette et al., 2014; Drenth et al., 2018; Ferrell et al., 2010; Hutti, 2015; Kopp, 2014; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013; Niederriter, 2009; Pye, 2016; Ramasamy-Venkatasalu et al., 2015; Ranse et al., 2012).

Holistic, individualized perinatal bereavement care.

Making bereavement care meaningful means providing holistic, individualized perinatal bereavement care (Lewis & Ahern, 2017; Ranse et al., 2012). Meaningful bereavement care is essential in end-of-life care because it supports the values, needs, and wishes of others when they may already be predisposed to feeling powerless (Evans, 2012; Lewis & Ahern, 2017; Ranse et al., 2012). Understanding perinatal grief from a holistic, individualized bereavement care perspective is therefore needed to discern individualized care, as a whole, beyond the traditional, theory-specific, way of knowing grief (Adams, 2009; Arbour & Wiegand, 2014; Evans, 2012; Kopp, 2014; Niederriter, 2009; Richeson et al., 2008). For holistic, individualized perinatal bereavement care, as part of a perinatal loss mentorship program and specifically with regards to perinatal grief theory, the following elements must be considered: 1) domains of care, 2) emotional labor and self-awareness, and 3) collaborative decision-making.

Domains of care.

The domains of care that encompass holistic bereavement care are physical, emotional, psychosocial, socio-cultural, and spiritual (Adams, 2009; Ayed et al., 2015; Drenth et al., 2018; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Niederriter, 2009; Nyatanga, 2012; Richeson et al., 2008; Steven et al., 2014). Each of these domains contribute to making

perinatal bereavement care individualized and holistic for bereaved families (Adams, 2009; Ayed et al., 2015; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Niederriter, 2009; Richeson et al., 2008; Steven et al., 2014). To understand each domain and how they fit into perinatal bereavement care, they should be introduced in a didactic or workshop-style setting (Ferrell et al., 2010; Koren et al., 2008).

The physical domain of care for the bereaved includes: 1) understanding pain physiology, 2) doing a comprehensive pain assessment, i.e., pain associated with the progression of labor and/or other discomforts, and 3) communicating to address pain and other symptoms and individualized personal values about pain and its management (Adams, 2010; Ayed et al., 2015; Ferrell et al., 2010; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Mahler, 2010; Murakami et al., 2015; Pitman, 2013; Temkin-Greener, 2009). These factors involve listening to the needs of the bereaved to appropriately address the physical domain of holistic care (Arbour & Wiegand, 2014; Drenth et al., 2018; Mahler, 2010; Murakami et al., 2015; Pitman, 2013). The emotional domain of holistic bereavement care entails: 1) assessing non-verbal cues and body language of the bereaved, 2) asking open-ended questions, 3) demonstrating nursing presence to determine emotional status and needs, and 4) tailoring presence, touch and emotional support in accordance with the needs of the bereaved patient and family (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Horey et al., 2015; King-Okoye & Arber, 2014; Lavoie et al., 2013; Vanderspank-Wright et al., 2011). The psychosocial and socio-cultural domain of care includes: 1) determining the psychosocial history and assessing the family dynamics through observation, 2) assessing and documenting family and financial support systems using open-ended questions, 3) asking about, recognizing, and incorporating cultural practices and norms that are individualized to the patient and family, and 4) providing resources

to meet the financial, cultural, and support-system needs of the bereaved family (Crawford et al., 2013; Drenth et al., 2018; Ferrell et al., 2010; Kataoka-Yahiro et al., 2017; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Nyatanga, 2012; Olausson & Ferrell, 2013). Lastly, the spiritual domain of care includes: 1) observing and asking open-ended questions about spiritual practices, and 2) ensuring that the bereaved family is connected with resources to fulfill their spiritual care needs (Adams, 2009, 2010; Ayed et al., 2015; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Niederriter, 2009; Steven et al., 2014; Vanderspank-Wright et al., 2011).

Thus, a didactic and comprehensive layout of the domains of holistic care is needed for a perinatal loss mentorship program, to prepare perinatal nurses for experiential learning, and ultimately, make bereavement care meaningful for the grieving family.

Emotional labor and self-awareness.

Emotional labor and self-awareness are features of holistic, individualized perinatal bereavement care (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). Emotional labor includes being present and empathetic, providing touch and using silence and active-listening skills (i.e., eye contact, body language), while being self-aware of its use and how it affects the bereaved family (Evans, 2012; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). Emotional labor endorses holistic bereavement care as it is a means of addressing the emotional domain of holistic care of the bereaved family (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008).

For bereavement care providers, self-awareness and having an awareness of the environment is necessary to use appropriate and individualized emotional labor, as in scenarios where touch and eye contact may not be culturally or otherwise acceptable (King-Okoye &

Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). Self-awareness, through self-reflection, requires experience to use it with confidence and should be recognized by perinatal nurses (Doucette et al., 2014; Sweeney et al., 2015). Although time and experience is part of the equation, perinatal nurses need to be aware of the relation between emotional labor and self-awareness and the linkages with holistic and individualized perinatal grief support (Evans, 2012; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008).

Collaborative decision-making.

Collaborative decision-making is an important component of didactic learning, translated through holistic, individualized perinatal bereavement care, in order to prepare the perinatal nurse with methods of its implementation in practice. Collaborative decision-making as translated through holistic, individualized perinatal bereavement care entails: 1) communicating with and considering input from health care providers and family members to make informed decisions, and 2) making bereavement care meaningful for the bereaved family, using the domains of holistic care to guide the decision-making processes (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011). When decisions are made in collaboration with the patient, the family and health care team is facilitating communication to ensure that: 1) care is being provided with insight and a transparency among all team members, 2) education gaps in practice are addressed, and 3) questions about the nursing care and the cultural, spiritual, social, and individual wishes of the bereaved family are being met (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011).

Collaborative decision-making involving the patient and family means: 1) involving the patient in the decision-making process, 2) educating the patient and family on what to expect

during the period of hospitalisation, 3) developing a care plan in collaboration with the patient and family, and 4) informing the patient and family about the involvement of the health care team and connecting them with the team as needed (Adams, 2009, 2010; Evans, 2012; Murakami et al., 2015; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012). Thus, the patient and family-led approach is valuable for determining how to individualize the needs of the family, and make the experience meaningful for the bereaved (Adams, 2009, 2010; Evans, 2012; Murakami et al., 2015; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012). Collaborative decision making with the patient and family also entails: 1) being resourceful, 2) demonstrating transparency and emotional labor, and 3) treating the patient and family as equals (Adams, 2009, 2010; Evans, 2012; Murakami et al., 2015; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012).

Collaborative decision making with the health care team entails open communication between the nurse, patient, family, and health care team to: 1) create a care plan informed by all individuals, 2) clarify the roles involved for communication purposes, and 3) ensure the patient and family feel empowered to seek access to the health care team, as needed (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Vanderspank-Wright et al., 2011). Collaborative decision making is a process of: 1) learning to respect the mentor-mentee domains in a mentoring partnership, 2) acknowledging and recognizing the viewpoints of the health care team, 3) respectfully communicating with team members and the bereaved, using empathy and a non-defensive approach, and 4) listening to and advocating for the patient's and family's wishes (Adams, 2009, 2010; Doucette et al., 2014; Evans, 2012; Hartley, 2011; Mahler, 2010;

Murakami et al., 2015; Niederriter, 2009; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Collaborative decision making facilitates communication for the holistic, individualized perinatal bereavement care, because it emphasizes positive communication outcomes and tailoring the care to meet the needs of all individuals (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Vanderspank-Wright et al., 2011). Collaborative decision making is an important component for a perinatal loss mentorship program, so that perinatal nurses can recognize its linkages and application in a mentorship partnership that develops partnerships between the health care team and the bereaved family (Adams, 2009, 2010; Doucette et al., 2014; Evans, 2012; Hartley, 2011; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Ranse et al., 2012; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Characteristics of reflection and debriefing in mentoring.

Reflection and debriefing are both important components in a perinatal loss mentorship program, because they help in navigating the emotional domain of care, associated with providing bereavement care (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Kopp, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011). Reflective practice is an overarching theme mentioned in the literature review and to implement it in mentoring, nurses must first be educated about its use in a didactic learning environment.

Reflection, or dialogue with oneself, is a process of learning that is implemented through self-talk, journal writing, and self-reflection about events and interactions (Crawford et al., 2013; Doucette et al., 2014; Gillett et al., 2016; Kopp, 2014; Malloy et al., 2013). Reflection is also used to address, prevent, and overcome emotional stressors that may arise in the end-of-life care

context (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Reflective practice is typically used on the learner's own terms (Foltz-Ramos, 2017; Pye, 2016), although in many cases, learners who fail to have self-awareness about their learning and development may require facilitated reflection by mentors, using guiding questions (Gillett et al., 2016). To promote learning and development in perinatal nurses in perinatal loss mentoring, 1) mentees must be familiarized with the value of reflection in learning and the different ways to reflect, and 2) mentors need to recognize when and how to facilitate and promote reflection (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Debriefing is a process of learning that incorporates dialogue with another. It is characterized by: 1) discussing fears, concerns, reactions, and emotional responses to events and interactions, 2) identifying what went well and areas that can be improved, and 3) developing an action plan in partnership with a peer or mentor, on how to move forward in nursing practice (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Debriefing is a necessary component of reflective practice, because it: 1) permits learners to recognize and gain insight from the educational and experiential contributions of their peers and mentors, and 2) ideally cultivates a safe environment for nurses to talk about their emotions and address their fears and concerns, in partnership with their team members (Crawford et al., 2013; Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lavoie et al., 2013; Lewis & Ahern, 2017; Malloy et al., 2013; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Thus, debriefing is valuable for promoting a positive working environment for nurses,

and is a significant component of perinatal loss mentorship since it promotes collaboration, partnership, and teamwork, and can create a workplace that permits the expression of feelings and insight from perinatal nurses (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Nursing self-care: Self-awareness and coping ability.

Educating nurses about self-care in the perinatal bereavement care context can prepare perinatal nurses for coping with and managing their emotional responses to perinatal loss (Adams, 2009, 2010; Arbour & Wiegand, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). The components of nursing self-care are self-awareness and coping mechanisms, which are composed of: 1) nursing attitudes, beliefs, values, and comfort with perinatal loss, 2) emotional stressors, and 3) coping mechanisms and cognitive restructuring. Each of these aspects of nursing self-care is crucial for perinatal nurses to comprehend, in order to train and prepare themselves with positive coping mechanisms and self-awareness about their coping abilities in bereavement care.

Nursing attitudes, beliefs, values and comfort with perinatal loss.

Nursing attitudes and the beliefs and values about and level of comfort with perinatal loss have major implications for the bereavement care provided by perinatal nurses to grieving families (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Terry & Carroll, 2008). Holistic and individualized bereavement perinatal care means having self-awareness about one's own attitudes, beliefs, and values about perinatal loss (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Terry & Carroll, 2008), which affect the level of comfort, willingness, and interest to provide bereavement care (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Terry & Carroll, 2008). Perinatal nurses without the

self-awareness about their attitudes, beliefs, and values about perinatal loss are at risk of being predisposed to feelings of anxiety, powerlessness, frustration, apprehension, and lack of confidence (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). These indicators of discomfort are important and need to be addressed didactically, in order to mentally prepare perinatal nurses for the possible contributors to emotional exhaustion, compassion fatigue, burnout, and moral distress (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Educators need to educate perinatal nurses about the different emotional responses towards perinatal loss to: 1) verify their normalcy, 2) promote knowledge and self-awareness of one's attitudes, beliefs, and values, 3) help perinatal nurses to determine their willingness to be bereavement care providers, and 4) provide self-care tools for perinatal nurses who are willing and able to continue (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). To promote self-awareness early on, it is important mentors utilize the didactic workshop – style environment to: 1) discuss and ask open-ended questions about their mentees' attitudes, beliefs, and values about perinatal loss, 2) assess the mentee's self-reflection abilities, 3) debrief with mentees about their attitudes, beliefs, and values and their willingness or comfort about dealing with perinatal loss, and 4) collaborate with mentees to develop a nursing self-care plan to address any emotional barriers to effective bereavement care, if applicable (King-Okoye & Arber, 2014; Evans, 2012; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Reflection and debriefing play noteworthy roles in developing self-awareness and in the mentee's assessment of his or her viewpoints about perinatal loss.

Emotional stressors.

A lack of emotional self-awareness increases perinatal nursing risk for emotional exhaustion, burnout, compassion fatigue, and moral distress (Arbour & Wiegand, 2014; Evans, 2012; Gillett et al., 2016; Levine et al., 2017; Malloy et al., 2013; Niederriter, 2009; Nyatanga, 2012). A number of necessary emotional stressors need to be addressed to help perinatal nurses develop self-awareness about their emotional responses. First, perinatal nurses must be educated about intrinsic and extrinsic awareness, to be able to accurately identify ways to manage their emotional stressors (Jones, 2016; Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014). Second, to prepare perinatal nurses for the consequences of the absence of emotional self-awareness, the ways in which a lack of self-awareness about emotional labor can influence nursing practice must be addressed (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). These elements of bereavement care can influence how perinatal nurses conduct self-care, and thus, should be considered for a perinatal loss mentorship program.

Intrinsic and extrinsic awareness.

To adequately address the emotional stressors encountered in the perinatal bereavement care setting, intrinsic and extrinsic forms of awareness are required (Jones, 2016; Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014). Intrinsic (internal) awareness for addressing emotional stressors include: the ability to self-talk, self-reflect, and determine one's learning needs on one's own (Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014). Alternatively, extrinsic awareness is related to outside sources like mentors, counsellors, leaders, and new and challenging working environments that promote knowledge development and awareness (Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014). The lack of intrinsic and extrinsic awareness would affect the ability of perinatal nurses to manage their emotional

and cognitive development and cope (Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014). Thus, for perinatal nurses to deal with the emotional stressors they may experience, they would need to: 1) first understand the different forms of awareness and their roles in emotional conditioning in regards to perinatal loss, and 2) then integrate the different forms of awareness, either in self-reflection journals or in debriefing interactions (Jones, 2016; Lewis & Ahern, 2017; Malloy et al., 2013; Steven et al., 2014).

Lack of emotional labor and self-awareness.

The act of being self-aware (intrinsically and/or extrinsically) while implementing emotional labor in the bereavement care process plays an important role in allowing nurses to manage or prevent emotional exhaustion, burnout, and compassion fatigue (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). The absence of emotional labor and self-awareness is associated with anger, frustration, powerlessness, anxiety and avoidance, and the compartmentalization of emotions (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008). These emotional responses and coping mechanisms create difficult working conditions for perinatal nurses that can negatively affect 1) patient care and the family experience 2) the unit and nursing morale, and 3) nursing and family relationships (King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008).

It is valuable that perinatal nurses be exposed to theoretical case scenarios on a lack of emotional labor and self-awareness, in order to 1) introduce them to poorly handed scenarios, 2) promote brainstorming among mentees, and 3) illustrate environments that might be devoid of nursing self-care to see the repercussions from poor emotional awareness of the self (Adams, 2009, 2010; Arbour & Wiegand, 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Murakami et al., 2015; Nyatanga, 2012; Terry & Carroll,

2008). Addressing the repercussions caused by a lack of self-awareness and emotional labor can promote critical thinking and a greater understanding of the role of emotions and self-awareness and reflection in bereavement care nursing (King-Okoye & Arber, 2014; Lewis & Ahern, 2017). Self-awareness and the role of emotional labor, or the lack thereof, is significant in conditioning perinatal nurses as emotionally intelligent and cognizant bereavement care providers (Adams, 2009, 2010; Arbour & Wiegand, 2014; Evans, 2012; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008).

Coping mechanisms and cognitive restructuring.

The awareness of both positive and unhelpful coping mechanisms is important for the didactic format of a perinatal loss mentorship program. Perinatal nursing coping ability, in the end-of-life care context, frames emotional wellness in the professional and personal lives of nurses, which also guides the bereavement experience for grieving families (Jones, 2016; Malloy et al., 2013; Parry, 2011; Ranse et al., 2012; Terry & Carroll, 2008). Being aware of both positive and unhelpful coping mechanisms is thus important for perinatal nurses in developing healthy coping and emotional behaviors (Lewis & Ahern, 2017). Thus, perinatal nurses should be educated about abandonment, avoidance, and compartmentalization, and involved in discussing: 1) what causes these unhelpful coping mechanisms, 2) their significance, and 3) how to avoid them in practice by being self-aware and adopting positive coping mechanisms (Terry & Carroll, 2008).

Cognitive restructuring: Self-management and collegial support.

Positive coping mechanisms include accessing mentor support and debriefing, boundary setting, intentional gratitude, and positive outlook (Foltz-Ramos, 2017; Lewis & Ahern, 2017).

Positive coping mechanisms should be examined to: 1) prepare perinatal nurses with positive ways to cope, 2) prepare perinatal nurses for the mentoring partnerships they may develop, and 3) set the foundation for understanding the role of cognitive restructuring in developing healthy emotional behaviors (Adams, 2009, 2010; Arbour & Wiegand, 2014; Foltz-Ramos, 2017; Lewis & Ahern, 2017).

Cognitive restructuring is useful for promoting healthy coping and emotional behaviors among perinatal nurses when caring for bereaved families (Adams, 2009, 2010; Lewis & Ahern, 2017). It entails the use of positive coping mechanisms, such as intentional gratitude and a positive outlook, and is a means to positively condition the mindset (Adams, 2009, 2010). Cognitive restructuring is meant to overcome and prevent unhelpful coping mechanisms through: 1) reflection and having an awareness of one's own emotions and coping abilities, and 2) partnerships and debriefing encounters with mentors and colleagues. Thus, cognitive restructuring: 1) builds partnerships, 2) develops emotional support, 3) cultivates a positive working environment for perinatal nurses, and 4) positivity conditions the mindset and environment (Adams, 2009, 2010; Lewis & Ahern, 2017; Malloy et al., 2013; Vanderspank-Wright et al., 2011). Cognitive restructuring promotes a positive environment for families and bereavement care providers, alike (Vanderspank-Wright et al., 2011). To prepare perinatal nurses for their experiential encounters and promote healthy nursing emotional development, cognitive restructuring and debriefing are necessary topics in the education of perinatal nurses (Adams, 2009, 2010; Arbour & Wiegand, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Vanderspank-Wright et al., 2011). These forms of nursing self-care are a means to empower perinatal nurses to learn to self-manage their emotions and grief, in the bereavement care context.

Nursing grief support.

Perinatal nurses need to be educated about the role and accessibility of formal grief support, to promote their awareness about accessing, managing, and using these formal resources for nursing grief (Evans, 2012; Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Murakami et al., 2015; Nyatanga, 2012; Steven et al., 2014; Vanderspank-Wright et al., 2011). Education about the role of formal grief counselling support from counsellors, social workers, spiritual care and/or nurse educators can help prepare perinatal nurses to use the resources and navigate the issues regarding bereavement care provider emotions and grief, regardless of whether or not they are resolved (Arbour & Wiegand, 2014; Evans, 2012; Foltz-Ramos, 2017; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Nyatanga, 2012; Pye, 2016 Ranse et al., 2012). Perinatal nurses should be familiar with the grief support team and the benefits and reasons for their presence in navigating nursing grief, and acknowledge external sources that are used to address the challenges of perinatal loss and develop healthy coping mechanisms (Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Steven et al., 2014).

During the didactic learning experience, examples need to be given that show the effectiveness of allied health and leadership in providing formal grief support, to provide the context of their relevance in practice and how they might be used by perinatal nurses (Arbour & Wiegand, 2014; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Lavoie, Blondeau & Martineau, 2013; Lewis & Ahern, 2017; Steven et al., 2014; Vanderspank-Wright et al., 2011). The didactic learning environment is an ideal setting to inform perinatal nurses of the role of formal grief counselling for healthy grief expression and for cultivating a supportive environment for nurses' work (Arbour & Wiegand, 2014; Evans, 2012; Horey et al., 2015; Lewis

& Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Olausson & Ferrell, 2013; Ranse et al., 2012; Vanderspank-Wright et al., 2011). Examples of formal grief support for positive emotional development and coping mechanisms include: 1) workshops for groups of perinatal nurses as part of the experiential learning component, and 2) one-to-one formal debriefing sessions with allied health and/or leadership in the practice setting (Arbour & Wiegand, 2014; Evans, 2012; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Ranse et al., 2012).

Education on formal grief support needs to be integrated into a perinatal loss mentorship program. Moreover, perinatal nurses need to be reassured that even if reflective practice fails to promote healthy emotional development, the support from formal grief counsellors is available to cultivate self-awareness and help nurses evolve as emotionally intelligent bereavement care providers (Jones, 2016; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Steven et al., 2014).

Communication skills.

Communication skills affect: 1) the patient and family experience, 2) nursing team collaboration and the ability to debrief, and 3) nursing coping abilities and morale and job satisfaction (Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011; Virani et al., 2014). These components are significant for cultivating a positive bereavement experience for patients, families, and care providers, which makes communication skills valuable to learn and understand (Crawford et al., 2013;

Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Sweeney et al., 2015). To foster the comprehension of communication skills, they must be included in a didactic component of a perinatal loss mentorship program. To prepare perinatal nurses with effective communication enhancement approaches, the skills must be understood before they are implemented.

Effective communication characteristics.

In a didactic environment, perinatal nurses should be educated about the characteristics of effective communication and given examples of how they are used in the care of families experiencing a perinatal loss (Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Kataoka-Yahiro et al., 2017; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011). Overall, effective communication entails active listening, open-ended questioning, and non-verbal communication skills that consider cultural norms, with examples of their implementation (Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Kataoka-Yahiro et al., 2017; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven et al., 2014; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011). Perinatal nurses must also be educated about why the effective communication tools are important to benefit patients, the families, and nurses (Crawford et al., 2013; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Sweeney et al., 2015).

Effective communication skills must be recognized for promoting communications between care providers, patients, and families, with the goal of minimizing negative feelings of powerlessness, helplessness, or neglect for the bereaved (Doucette et al., 2014; Evans, 2012;

Foltz-Ramos, 2017; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Temkin-Greener et al., 2009; Vanderspank-Wright et al., 2011). The characteristics of effective communication promote patient and family involvement in decision making and the overall bereavement process, for promoting a positive experience for the grieving family (Ramasamy Venkatasalu et al., 2015; Steven et al., 2014). Learning about effective communication and how it relates to patients and families can foster rumination and consideration of the patient and family as a core component of bereavement care, before the perinatal nurse has experiential encounters (Crawford et al., 2013; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Sweeney et al., 2015).

Understanding the characteristics of effective communication is also useful for preparing perinatal nurses with the tools to handle difficult questions and topics involving death and loss, 'breaking bad news,' and handling strong emotions (Crawford et al., 2013; Ferrell et al., 2010; Gillett et al., 2016; Nyatanga, 2012; King-Okoye & Arber, 2014; Sweeney et al., 2015). Because perinatal nurses are likely to encounter these situations, carefully formulated case studies should be developed to prepare the nurses to use communication skills in different scenarios (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). The goal is to bridge the gap between communication skills in theory and practice, so that perinatal nurses will be confident and have the foundation for being effective communicators (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; King-Okoye & Arber, 2014; Kopp, 2014; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Steven

et al., 2014). In addition, discussing these topics is an active approach to prepare perinatal nurses to handle difficult scenarios, develop their foundational communication skills, and address any nuances of the nurses' coping abilities, using the communications skills they have been taught (Crawford et al., 2013; Ferrell et al., 2010; Gillett et al., 2016; Nyatanga, 2012; King-Okoye & Arber, 2014; Sweeney et al., 2015). Accordingly, by endorsing the perinatal nurses' communication skills, they can see that their contribution and role is valued and recognized in the bereavement care process.

Relevance of self-reflection and debriefing.

Another important part of using effective communication skills is being aware of one's abilities, through self-reflection and debriefing with peers and mentors (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Kopp, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011). Perinatal nurses need to recognize that communication skills are complex and require the development of emotional labor and emotional intelligence (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011).

Considering the complexity in developing communication skills, perinatal nurses should be educated about the relevance of self-awareness and reflective practice, to shape and refine their communication abilities (Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Horey et al., 2015; Jones, 2016; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pitman, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014; Sweeney et al., 2015; Temkin-Greener et al., 2009; Vanderspank-

Wright et al., 2011; Virani et al., 2014). By using examples to identify and link together: 1) communication skill development, 2) emotional labor and emotional intelligence, and 3) self-awareness and reflective practice, their importance in practice can be demonstrated (Arbour & Wiegand, 2014; Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Nyatanga, 2012; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

To further develop effective communication abilities, perinatal nurses need to understand: 1) the consequences of a lack of communication ability, for patients and families, and the morale of perinatal nurses, and 2) the association between communication and self-awareness and reflective practice (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Kopp, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011). Thus, perinatal nurses must understand the role of: 1) self-reflection, to gain an awareness of their communication abilities, and 2) debriefing with mentors, to determine any gaps in communication (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Self-reflection and debriefing are crucial for developing one's communication abilities, and for fostering emotional intelligence (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011). Therefore, self-awareness and the reflective practice, used to develop effective communication, is important content for the didactic setting. Perinatal nurses need to understand

the different kinds of communication tools that they will need to cultivate a positive bereavement experience for themselves and the family.

Experiential Learning

Experiential learning is the second major component for a perinatal loss mentorship program. It is part of a blended learning approach and follows didactic, workshop-style learning (Arbour & Wiegand, 2014; Doucette et al., 2014; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Experiential learning is an opportunity for perinatal nurses to implement the tools they have learned in a simulated and mentoring partnership (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Experiential learning is an active, "hands-on" method that considers theory to help lay the foundation for the simulated and clinical-based learning (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011).

Experiential learning is also an opportunity for perinatal nurses to work through the nuances of bereavement care, including overcoming communication and emotional barriers, and learning to cope with bereavement, while in partnership with expert perinatal nurses who act as mentors (Arbour & Wiegand, 2014; Doucette et al., 2014; Jones, 2016; King-Okoye & Arber,

2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Experiential learning is an active approach that uses real encounters to: 1) educate perinatal nurses navigating bereavement care to cultivate positive experiences for families, and 2) support perinatal nurses to learn effective communicating and coping, guided by reflective practice (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Experiential learning is necessary to foster positive experiences for bereaved families and perinatal nurses, and thus, it is a major component of a perinatal loss mentorship program.

The synthesized literature suggests using two approaches for implementing experiential learning: 1) simulated scenarios and 2) one-on-one mentorship (Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; Jones, 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Both of these avenues are needed to prepare nurses and address the complexities of bereavement care while becoming an emotionally intelligent bereavement care provider (Arbour & Wiegand, 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017).

Simulated scenario.

Simulation is an opportunity for perinatal nurses to role-play, discuss, and debrief to work on their 1) technical skills (i.e., pain management and labor and delivery process for an

anticipated or unanticipated perinatal loss), and 2) non-technical skills (i.e., effective communication and emotional labor (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Lewis & Ahern, 2017; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Simulation allows perinatal nurses to ask questions, receive and give feedback, practice their skills, and prepare for real encounters using adequate tools (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Parry, 2011; Pye, 2016; Sweeney et al., 2015). Simulation is also an opportunity for perinatal nurses to work on their confidence and comfort with perinatal loss (Foltz-Ramos, 2017; Gillett et al., 2016; Kopp, 2014; Niederriter, 2009; Olausson & Ferrell, 2013; Parry, 2011). Considering the value of simulation, especially as a blended approach to learning, it is important to incorporate in a perinatal loss mentorship program. Simulation would be reasonable for the conclusion of workshop-style learning and introduction to one-on-one mentorship and include: 1) a description of a perinatal loss scenario, 2) participation in a simulated scenario, 3) case debriefing (facilitated reflection), and 4) self-reflection and debriefing self-management.

Description of a perinatal loss scenario.

One of the early steps in simulated learning is to describe a perinatal loss scenario, to give perinatal nurses an opportunity to cognitively prepare for the different kinds of contexts in which they will be situated (Foltz-Ramos, 2017). The description of a perinatal loss scenario is the background knowledge to inform perinatal nurses of the typical settings they may come across (King-Okoye & Arber, 2014). Thus, the description is a mandatory step to prepare perinatal nurses with an opportunity to pick out themes for critical thinking, communication building, collaboration, and nursing interventions in which they will likely participate (Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Pye, 2016). This step is an excellent exercise for

nurses to indicate their plan of action prior to participating in the scenario and when debriefing with the simulation group (Foltz-Ramos, 2017).

Participation in a simulated experience.

Participation in a simulated experience is the step that follows the description of a perinatal loss scenario. Participation is an opportunity for perinatal nurses to: 1) make mistakes and practice their skills, 2) absorb the different types of contexts they will come across in the bereavement care setting, 3) be introduced to their role as bereavement care providers before entering the practice setting, 4) ask questions about any gaps in knowledge translation, from theory to practice, 5) work on their communication skills and collaboration with team members, and 6) develop questions for feedback, discussion, and debriefing with mentors, to develop their cognitive and affective skills (Crawford et al., 2013; Gillett et al., 2016; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016). Participation in a simulated experience is a critical component of a perinatal loss mentorship program because it fosters active participation and integrative skill use, and provides an interactive opportunity for perinatal nurses to immerse themselves in the contexts they will likely encounter (Crawford et al., 2013; Gillett et al., 2016; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016).

Case debriefing: Facilitated reflection.

Case debriefing is an opportunity for mentors and educators to facilitate reflection in perinatal nurses after they participate in a perinatal loss simulation scenario. Case debriefing requires mentors and educators to ask open-ended and specific questions to prompt the nurses to discuss: 1) their cognitive and affective responses to the case, 2) how they integrate learning theory into the simulation, 3) the scenario including what went well and what could have gone better, and 4) areas for improvement in their mentorship experience and future practice (Foltz-

Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014). Overall, case debriefing is necessary to facilitate reflection in perinatal nurses, especially for those who may be struggling to self-reflect and/or those needing prompts to link theory with practice (Crawford et al., 2013; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lavoie et al., 2013; Lewis & Ahern, 2017; Malloy et al., 2013; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Applying holistic perinatal bereavement care.

The case debriefing component is also an opportunity for mentors to start conversations about holistic perinatal bereavement care and what it looks like in practice. The facilitated reflection requires mentors to: 1) ask perinatal nurses how they apply holistic perinatal bereavement care, and 2) discuss each of the domains of holistic perinatal bereavement care and how they translate into practice (Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Kopp, 2014). Case debriefing about the physical, emotional, psychosocial, socio-cultural, and spiritual domains of care involves the participation of perinatal nurses to address their use or lack of use during the simulation (Lewis & Ahern, 2017). As a result, facilitated reflection of a case is a means to promote perinatal nurses' awareness of theory integration into practice, and to support nurses with cognitive and affective clarity and insight (Foltz-Ramos, 2017).

Using reflection and debriefing self-management.

Debriefing with mentors after a simulation is also a chance for perinatal nurses to: 1) articulate their nursing self-awareness and self-care, and 2) discuss effective communication and emotional labor (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; Hales & Hawryluck, 2008; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016; Sweeney et al., 2015; Vanderspank-Wright et al., 2011). Self-awareness and self-care and effective communication and emotional labor are all significant aspects of perinatal bereavement practice,

as evidenced by the review of literature (Adams, 2009, 2010; Arbour & Wiegand, 2014; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Kataoka-Yahiro et al., 2017; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Olausson & Ferrell, 2013; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Steven et al., 2014; Temkin-Greener et al., 2009; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). These aspects need to be discussed after the simulation, to promote reflecting on attitudes and coping abilities and an awareness of communication abilities, in preparation for the experiences that will be encountered in practice (Crawford et al., 2013; Pye, 2016).

Articulating nurses' self-awareness and self-care.

Articulating nurses' self-awareness and self-care requires mentors to: 1) ask perinatal nurses to reflect on how they feel about bereavement care, 2) prompt perinatal nurses to reflect on their attitudes and coping abilities during the perinatal loss simulation, and 3) ask perinatal nurses to identify examples of helpful coping mechanisms and how they would implement them in practice (King-Okoye & Arber, 2014; Evans, 2012; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). The debriefing process is intended to promote reflection and discussion of complex emotions that may be hard to identify, as the perinatal nurse transitions to become a bereavement care provider (Adams, 2009, 2010; Arbour & Wiegand, 2014; Foltz-Ramos, 2017; Lewis & Ahern, 2017). Debriefing about self-awareness and nurses' self-care is especially valuable, because it: 1) promotes an understanding of the significance and need for self-awareness and self-care in practice, 2) introduces perinatal nurses to a culture of debriefing about self-care and self-management for consideration in future practice, and 3) fosters perinatal nurses' awareness that their emotional management and coping abilities are

recognized and valued (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Evans, 2012; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Practising effective communication and developing emotional labor.

Discussing effective communication and developing and demonstrating emotional labor are also important components of debriefing after a simulated scenario (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Kopp, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011). Debriefing about effective communication and developing emotional labor requires mentors to ask perinatal nurses to: 1) reflect on and discuss how they communicate, 2) discuss the significance of effective communication, 3) provide examples of effective communication from the simulation and for future practice, and 4) discuss the significance of developing emotional labor and emotional intelligence in the bereavement care context (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011).

Debriefing thus helps perinatal nurses: 1) develop an awareness of their communication abilities, 2) understand the significance of using effective communication in practice, and 3) understand the effects of emotional labor and emotional intelligence development on effective communication development (Arbour & Wiegand, 2014; Ayed et al., 2015; Crawford et al., 2013; Doucette et al., 2014; Evans, 2012; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Mahler, 2010; Malloy et al., 2013; Nyatanga, 2012; Olausson & Ferrell, 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). The process of debriefing with perinatal nurses and prompting them to reflect on their theoretical knowledge, communication abilities, and emotional labor development is needed to help them gain: 1) an awareness of their current knowledge and practice, and 2) insight into

areas that need to be improved to shape them into effective communicators (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Debriefing with perinatal nurses enables mentors to observe and determine the novice perinatal nurses who might require further support with their: 1) understanding about applying holistic perinatal bereavement care, 2) coping abilities, and 3) understanding of effective communication and how to use it in practice (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). These aspects of debriefing after a simulated scenario are crucial for mentally and emotionally preparing perinatal nurses and for their eventual independence to provide perinatal bereavement care (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

One-on-one mentorship.

Following simulated learning, perinatal nurses have an opportunity to collaborate with nursing mentors to: 1) use their theoretical knowledge gained from the didactic setting, 2) experience caring for bereaved families and learning to self-regulate during a perinatal loss, and 3) use mentoring to cultivate a supportive environment for their future as perinatal nurses (Arbour & Wiegand, 2014; Doucette et al., 2014; Evans, 2012; Hartley, 2011; Mahler, 2010; Murakami et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). One-on-one mentoring between a mentor and mentee after the simulated scenario: 1) takes place in a real perinatal loss scenario, 2) involves post-mentorship reflection and debriefing, 3) involves follow-

up conversations and being ready for independence, and 4) leads to future mentoring opportunities, as mentees often become mentors.

Mentoring in a real perinatal loss scenario.

The first step in implementing one-on-one mentoring is the perinatal nurse being exposed to clinical experience and learning, first hand, the processes of holistic perinatal bereavement care (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Pye, 2016). A mentoring partnership, during clinical work, provides an opportunity for mentees to observe, participate in, and recognize the care they will be providing, the interactions in which they may be involved, and the kinds of feelings and emotions they may experience (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Pye, 2016). The clinical experience brings a reality to the learning process, while the mentoring partnership provides cognitive and affective support for nurses who are learning to become bereavement care providers (Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Koren et al., 2008; Niederriter, 2009; Pye, 2016). Mentoring is an important component of a perinatal loss mentorship program, because it helps to support and evaluate the mentee's cognitive and affective learning. The clinical experience is needed for mentees to self-reflect and debrief with others, to: 1) establish their learning needs, and 2) learn how to navigate their role and ability to care, moving forward (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016).

Post-mentorship reflection and debriefing.

Following observation and participation in a real perinatal loss situation, mentoring allows perinatal nurses to reflect on their experience and debrief with mentors (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016). Post-mentorship reflection and debriefing is a necessary step for perinatal nurses to cognitively and affectively learn and grow from the encounters and the challenges they have faced (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Pye, 2016). Although the learning and growing process may take time, post-mentorship reflection and debriefing can instill positive coping abilities for perinatal nurses, as they navigate any cognitive and/or emotional barriers along the way (Arbour & Wiegand, 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011). Post-mentorship reflection and debriefing occurs through: 1) self-reflection and journal writing, 2) facilitated reflection and debriefing with a mentor, and 3) development of a communication enhancement approach (Crawford et al., 2013; Gillett et al., 2016; Kopp, 2014).

Self-reflection and journal writing.

Self-reflection after a perinatal loss encounter, in a mentoring partnership, is crucial for helping perinatal nurses discern their: 1) attitudes and feelings towards perinatal loss and providing bereavement care, 2) coping abilities and emotional stressors, 3) communication abilities, and 4) cognitive and affective learning needs (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Kopp, 2014; Lewis & Ahern, 2017; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011). For some nurses, self-reflection may be easy, but for others, introspection may be needed through journal writing (Crawford et al., 2013; Kopp, 2014). Journal writing is an ideal way for mentees to self-reflect

on their own terms, because it encourages mentees to carefully think about their observations, participation, and overall experience (Crawford et al., 2013; Kopp, 2014). Journal writing also helps mentors to comprehend their mentees' thought processes and emotional standpoints, so that mentors can individualize their moral support and knowledge support for perinatal nurses (Crawford et al., 2013; Kopp, 2014). Journal writing helps: 1) mentees reflect on their own practice, 2) communication between mentors and mentees to determine learning needs and barriers to practice, and 3) mentors evaluate their mentees' knowledge and emotional readiness for the bereavement care context (Crawford et al., 2013; Kopp, 2014). It is important to note that due to the amount and depth of information shared in the journal writing process and to preserve a trusting mentor-mentee environment, it is crucial mentors and mentees incorporate a verbal and/or written privacy-confidentiality agreement.

Facilitated reflection and debriefing with mentor.

In the post-mentorship debriefing process, mentees meet their mentors to discuss: 1) the overall experience, 2) their thoughts and feelings about the perinatal loss experience and how it went, from the mentee's perspective, 3) the mentee's coping and communication abilities, 4) emotional barriers and knowledge gaps, 5) areas for improvement and the steps required to facilitate the change, and 6) the mentee's interest in moving forward as a bereavement care provider (Doucette et al., 2014; Gillett et al., 2016; King-Okoye & Arber, 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Debriefing with the mentor is important for the mentee's successful navigation of the mentoring experience (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). Debriefing also helps to cultivate a safe and supportive environment for perinatal nurses and empowers them to discuss

their thoughts, feelings, and comprehension of perinatal loss and bereavement care (Doucette et al., 2014; Lewis & Ahern, 2017). It contributes to a work environment that promotes collaboration, team work, teaching, and learning among perinatal nurses (Adams, 2009, 2010; Evans, 2012; Hartley, 2011; Jones, 2016; Mahler, 2010; Murakami et al., 2015; Niederriter, 2009; Pye, 2016; Sweeney et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). In debriefing, the mentor and mentee act as role models for one another and work together in a non-hierarchical shared learning process, to solve problems and promote cognitive and affective clarity (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011).

Although debriefing is frequently highlighted in the didactic learning environment, it may also require some facilitated reflection on the part of the mentor (Doucette et al., 2014). For debriefing, mentors need to: 1) be self-aware 2) facilitate discussion in order to gain awareness of their mentee's perspective, and 3) communicate effectively to foster a safe environment for the mentees (Doucette et al., 2014).

Development of a communication enhancement approach.

During the post-mentorship reflection and debriefing, communication skills must be part of the reflections, and in particular, a communication enhancement approach must be developed (Crawford et al., 2013; Doucette et al., 2014; Foltz-Ramos, 2017; Gillett et al., 2016; King-Okoye & Arber, 2014; Olausson & Ferrell, 2013; Vanderspank-Wright et al., 2011). Mentees need to use their observations and participation in clinical experiences to debrief and reflect on their communication abilities and areas to be improved (Crawford et al., 2013; Gillett et al., 2016; Niederriter, 2009; Pye, 2016). The communication enhancement approach can include: 1) positive coping mechanisms, 2) emotional labor, and 3) effective communication characteristics

(Lewis & Ahern, 2017; Olausson & Ferrell, 2013), depending on the needs of the mentee. Such components, within the bereavement care context, are needed to promote: 1) positive experiences for the bereaved family, 2) positive self-care for nurses, and 3) the development of emotional intelligence (Arbour & Wiegand, 2014; Doucette et al., 2014; Lewis & Ahern, 2017). Mentors must foster the development of individualized communication enhancement approaches by considering personalized perinatal nursing learning needs and styles for developing their mentees' positive coping and communication abilities (Crawford et al., 2013; Foltz-Ramos, 2017; Niederriter, 2009; Pye, 2016; Steven et al., 2014). The debriefing with mentees should encourage them to reflect on their communication, the areas they can improve, and the interventions they can implement to effect the changes (Crawford et al., 2013; Niederriter, 2009; Pye, 2016; Steven et al., 2014). Post-mentorship reflection and debriefing to develop a communication enhancement approaches is meaningful for: 1) the mentee's awareness of their communication abilities and emotions, and 2) for mentors, as role-models, to illustrate effective communication characteristics and positive coping mechanisms (Crawford et al., 2013; Doucette et al., 2014; Gillett et al., 2016; Jones, 2016; Kopp, 2014; Lewis & Ahern, 2017; Pye, 2016; Steven et al., 2014; Sweeney et al., 2015; Vanderspank-Wright et al., 2011).

Developing an enhanced communications approach is a crucial step, because it empowers perinatal nurses to reflect on their integrated holistic perinatal bereavement care, nursing self-care, coping, communication, and emotional labor in their individualized perinatal bereavement experiences (Crawford et al., 2013; Doucette et al., 2014; Jones, 2016; Niederriter, 2009; Steven et al., 2014). Thus, an individualized communication enhancement approach can be used for post-mentorship debriefing sessions, because it links theoretical components to individualized

experiential learning experiences, to develop positive coping and communication skills (Crawford et al., 2013; Doucette et al., 2014; Jones, 2016; Niederriter, 2009; Steven et al., 2014).

Mentorship follow-up conversations and determining the readiness for practice.

Mentors and mentees must also discuss the mentee's readiness for practice. This component requires mentees to demonstrate, using their journal writing and debriefing, their readiness to be bereavement care providers (Doucette et al., 2014; Steven et al., 2014). This process also requires mentors to evaluate their mentees' non-verbal and verbal cues to determine mentee willingness and confidence for independent practice (Doucette et al., 2014; Steven et al., 2014). Although this step follows reflection and debriefing, it may take several days to weeks to complete, depending on the perinatal nurse's number of clinical experiences (Steven et al., 2014; Vanderspank-Wright et al., 2011). This step is also a follow-up conversation to the assessment of the mentee's knowledge and practice development, which in turn, determines the readiness for practice in the perinatal loss bereavement care context (Doucette et al., 2014; Steven et al., 2014). This component is necessary for supporting perinatal nurses being mentored, and without it, it would be difficult to gauge the comfort and confidence of perinatal nurses for bereavement care (Doucette et al., 2014; Steven et al., 2014).

Future mentoring opportunities: Mentees becoming mentors.

Another important component for a perinatal loss mentorship program is the cycle of mentoring. Mentors and mentees may follow-up informally at any point in a perinatal nurse's development as a bereavement care provider to discuss the mentee's possible interest in becoming a mentor for novice perinatal nurses (Vanderspank-Wright et al., 2011). By encouraging experienced nurses to become mentors, a culture of teamwork and collaboration is cultivated (Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hartley, 2011; Horey et al.,

2015; Jones, 2016; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). The process may not be of interest to everyone or, for some perinatal nurses, their interest may occur later (Doucette et al., 2014; Steven et al., 2014).

In any case, the cycle of mentoring is valuable, because it fosters a working environment that: 1) recognizes the need to support other nurses, 2) prioritizes education and teaching for novice perinatal nurses, and 3) recognizes the need to promote quality bereavement care (Doucette et al., 2014; Evans, 2012; Hartley, 2011; Haugan & Hanssen, 2012; Horey et al., 2015; Jones, 2016; Mahler, 2010; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). Perinatal nurses should be empowered to self-reflect and discuss their motivation to become future mentors and support their colleagues, which would continue to promote meaningful bereavement care for grieving families(Crawford et al., 2013; Doucette et al., 2014; Lewis & Ahern, 2017; Vanderspank-Wright et al., 2011).

Summary

Chapter four addressed the components and structure needed for a perinatal loss mentorship program. Each component plays a dynamic role in: 1) cultivating holistic individualized perinatal bereavement care for grieving families, and 2) constructing cognitive and emotional support for perinatal nurses providing bereavement care. The components: 1) are based on the literature synthesis and thus, empirically driven, 2) involve a step-by-step process to navigate the nuances of perinatal loss and bereavement care, and 3) are enacted through a didactic and experiential learning structure that promotes theory and knowledge transfer for such challenging topics as perinatal loss. In this chapter, the components to be implemented are comprehensively described and supported by empirical evidence.

Chapter 5: Program Contributions and Implications for Practice

This chapter describes the contributions of the perinatal loss mentorship program, implications for nursing practice, and the research and education implications. The contributions of the program and the implications for nursing practice are the 1) tying together of the components, 2) creating nursing awareness and discussions about the expected changes, and 3) fostering change and new ways to implement the program in practice.

Contributions of the Perinatal Loss Mentorship Program

The perinatal loss mentorship program will make several contributions, including: 1) cultivating a culture of mentoring, communication, and collaboration among perinatal nurses, 2) promoting holistic, individualized family-centered perinatal bereavement care, and 3) possibly affecting the practice of other health care providers.

Culture of mentoring, communication, and collaboration.

The components of the perinatal loss mentorship program I have described, with didactic workshops, simulations, and practice cases will likely foster a supportive work environment for perinatal nurses (Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hartley, 2011; Horey et al., 2015; Jones, 2016; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014), because it promotes mentoring, communication, and collaboration (Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hartley, 2011; Horey et al., 2015; Jones, 2016; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

The program is especially valuable because it promotes an environment for perinatal nurses to access moral and educational support, which has been emphasized in the literature (Doucette et al., 2014; Evans, 2012; Hartley, 2011; Haugan & Hanssen, 2012; Horey et al., 2015;

Jones, 2016; Mahler, 2010; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

The perinatal loss mentorship program I have designed uses a holistic lens to meet the educational and emotional needs of learners with peer support and educational resources that will foster the emotional and cognitive growth of perinatal nurses in a positive workplace (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Vanderspank-Wright et al., 2011). In particular, the mentorship program allows mentors and mentees to learn from and support one another, just as Wagner (2005b) claimed in the caring mentorship model (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011). The program fits with the literature which emphasizes the importance of providing perinatal nurses with a positive foundation as they learn to navigate the emotionally charged processes of providing grief support for bereaved families (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011). The mentorship program is not only aimed at mentors and mentees but also at a positive culture change, which is necessary since it prioritizes optimal family care through support and education for perinatal nurses (Doucette et al., 2014; Evans, 2012; Hartley, 2011; Haugan & Hanssen, 2012; Horey et al., 2015; Jones, 2016; Mahler, 2010; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

The program contributes to developing a culture of communication and collaboration, which is an overarching theme in the literature. In concert with the literature, the perinatal loss mentorship program emphasizes communication and collaboration skills (Doucette et al., 2014; Drenth et al., 2018; Hartley, 2011; Virani et al., 2014). It enables perinatal nurses to acquire role

model skills for communicating and collaborating with bereaved families, nursing mentors, nurse colleagues, and members of the inter-disciplinary team (Doucette et al., 2014; Lewis & Ahern, 2017; Malloy et al., 2013; Ranse et al., 2012; Terry & Carroll, 2008; Vanderspank-Wright et al., 2011). As suggested by the literature, the perinatal loss program cultivates: 1) a caring perinatal nursing environment with communication, team work, and collaboration among peers and interdisciplinary team members, and 2) nurse-family relationships that prioritize family-led decision making and collaboration with effective communication in interactions and processes (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011).

Holistic, individualized family-centered perinatal bereavement care.

The perinatal loss mentorship program contributes by encouraging holistic, individualized family-centered perinatal bereavement care. The program components support the providing of optimal care for families experiencing a perinatal loss (Adams, 2009, 2010; Ayed et al., 2015; Drenth et al., 2018; Evans, 2012; Ferrell et al., 2010; Howe & Scott, 2012; Lewis & Ahern, 2017; Murakami et al., 2015; Niederriter, 2009; Nyatanga, 2012; Ramasamy Venkatasalu et al., 2015; Ranse et al., 2012; Richeson et al., 2008; Steven et al., 2014). As described in the literature, holistic, individualized family-centered perinatal bereavement care is necessary for enriching the family-nurse relation and the overall family experience (Arbour & Wiegand, 2014; Doucette et al., 2014; Ferrell et al., 2010; Malloy et al., 2013; Murakami et al., 2015; Olausson & Ferrell, 2013).

Contributions to the professional development of other care providers.

The perinatal loss mentorship program, through experiential learning and blended learning about holistic and individualized perinatal bereavement care, effective communication

and collaboration, nursing self-care and peer support, and reflection and debriefing can influence the practice of care providers from their exposure to nurses who have advanced knowledge of palliative practice in perinatal loss. The components help optimize patient and family experiences and improve nursing support and resources for learning (Drenth, 2018; Evans, 2012; Foltz-Ramos, 2017; Jones, 2016; Koren et al., 2008; Mahler, 2010; Malloy et al., 2013; Niederriter, 2009; Parry, 2011; Pitman, 2013; Pye, 2016). The utility of the perinatal loss mentorship program comes from improving practice in the maternity care context.

Implications for Nursing Practice

The program has numerous implications for nursing practice, such as: 1) promoting moral resilience, 2) improving interprofessional collaboration, 3) bolstering the support from senior management, and 4) promoting an ideology of mentees becoming mentors.

Fostering moral resilience.

The perinatal loss mentorship program can foster nurses' moral resilience to reduce nursing burnout, distress, and poor nursing retention that are the result of ineffective coping, ineffective self-care and self-awareness, and discomfort with bereavement care. Moral resilience is also a key component of a positive working environment (Arbour & Wiegand, 2014; Evans, 2012; Gillett et al., 2016; Levine et al., 2017; Malloy et al., 2013; Niederriter, 2009; Nyatanga, 2012). The workshop emphasizes that nursing distress and burnout are likely outcomes in the grief and loss context, and effective coping methods are necessary for nursing practice. By showing nursing leaders how effective the program can be for practice, the workshop can: 1) change the current nursing climate for distressed or burnt-out perinatal nurses, and 2) promote greater nursing retention (Adams, 2010; Vanderspank-Wright et al., 2011). Fostering moral

resilience is critically important for nursing practice to promote positive perinatal nursing experiences and enhance perinatal nurse retention.

Improving interprofessional collaboration.

Interprofessional collaboration involves communication, collaboration, peer support, and mentoring, which are all significant components of the perinatal loss mentorship program. These critical components are meant to support perinatal nurses' communication and collaboration with other health care team members, physicians, nursing team members, and members of allied health groups (Adams, 2009, 2010; Drenth et al., 2018; Evans, 2012; Hales & Hawryluck, 2008; Niederriter, 2009; Pye, 2016; Vanderspank-Wright et al., 2011).

Implications for senior management.

The program requires support from senior management, especially with regards to funding. As a result, a cultural shift can be created through the effects on families and on the morale and retention of nurses. Some of the outcomes may help in seeking funding to support the perinatal nursing staff in didactic, workshop settings, simulated experiences and in the experiential mentoring process (Drenth et al., 2018). Moral support from senior management would also lead directly to a culture change as leadership and management attempt to empower nurses to adopt the program in practice (Olausson & Ferrell, 2013).

Mentees becoming mentors.

The perinatal loss mentorship program emphasizes educating and supporting perinatal nurses with mentoring, which involves cultivating a culture of mentees becoming mentors. Because mentees are exposed to the mentoring culture, they are also exposed to mentors as role models with the education and mentoring tools to promote a cycle of mentoring (Doucette et al., 2014; Drenth et al., 2018; Evans, 2012; Hartley, 2011; Horey et al., 2015; Jones, 2016;

Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014). The process of mentees becoming mentors supports their behavior as role models, and the environment by promoting team work and collaborations with perinatal nurses (Doucette et al., 2014; Evans, 2012; Hartley, 2011; Haugan & Hanssen, 2012; Horey et al., 2015; Jones, 2016; Mahler, 2010; Ramasamy Venkatasalu et al., 2015; Vanderspank-Wright et al., 2011; Virani et al., 2014).

Research and Nursing Education Implications

To cultivate change and improve future practice, future research can involve the planning and evaluation of the perinatal loss mentorship program. The type of research that could help evaluate the program could use practical tools like the logic model framework, based on the program-action logic model (2003). The logic model has been used for program planning in educational settings, and it is relevant to nursing education and mentoring, and thus, to the perinatal loss mentorship program (Dillon, Barga & Goodin, 2012). The logic model is helpful for providing step-by-step visualizations and methods for executing the program, which would also serve to evaluate the perinatal loss mentorship program (Hayes et al., 2011; Pye, 2016). Using the logic model framework creates implications for future research since it can determine possible barriers or facilitators to the program and the evaluation strategy can enhance the program to better support the perinatal nurses.

The process of evaluation can also enhance the perinatal nurses' level of support and satisfaction in the bereavement care context, using evidence for the mentoring process and experiences of mentors and mentees. The evaluation can also determine any gaps in the program or in the nursing education that would need further development. These features could also be generalized beyond the perinatal nursing specialty. Overall, the perinatal loss mentorship

program and its evaluation could be beneficial to nursing education and to disciplines that are outside of the nursing care settings.

Summary

The perinatal loss mentorship program can address some of the nuances of caring for bereaved families while nurses are mentored in the perinatal bereavement care context. The program components appropriately address concerns raised in the literature about the quality of nursing care for bereaved families in the perinatal context and the effects on nurses who may be inadequately prepared to manage bereavement. Because of the program's positive influences on families and nurses, its implementation would be expected to foster a supportive environment for bereaved families and perinatal nurses, alike.

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