Care after death: Bereaved family experiences of a nurse-led supported viewing service

Wendy Walker, Jennifer Jones, Stacey Owen, Peter Kevern and Nikolaos Efstathiou

Abstract

Background: Viewing the deceased person is an integral part of hospital-based bereavement care and support. To date, research to guide this practice is scarce. **Aim:** To describe and interpret the bereaved family lived experience of an in-hospital supported viewing service situated in an acute hospital facility in the UK. A specific objective was to uncover and examine personal reflections on the choices and care provided. **Methods:** A qualitative exploratory design involving telephone interviews with ten family members, bereaved of an adult relative. Data were subjected to interpretative phenomenological analysis. **Results:** Three group experiential themes and seven subthemes were developed from the data. Thematic findings provide insights into the context of viewing and family care, informed choice and the reasons behind a decision to view, personal preferences, observations and reactions to viewing, the intimacy of the viewing experience and the hallmarks of quality care. **Conclusion:** The acute hospital, as a core provider of end-of-life care requires a workforce who are skilled to provide practical and relational care after death. The quality of care in preparing and presenting the deceased person for viewing, the ambience of the viewing facility and a compassionate, person-centred approach appeared central to a positive viewing experience. Consideration should be given to the supportive role of a specialist bereavement nurse and interprofessional team contributions to viewing practices and care.

Key words: bereavement ● family ● interview ● qualitative ● viewing

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Supporting a family around the time of death of a loved one and afterwards is an integral part of quality end-of-life (EoL) care (National Palliative and End of Life Care Partnership, 2021). Of importance is the provision of timely, personalised and culturally sensitive nursing care for the deceased person and those important to them (Henry and Wilson, 2012). Care after death includes viewing the deceased person and viewing facilities and arrangements are a feature of hospital-based bereavement care (Naef et al, 2020; Green et al, 2024). A viewing may be facilitated in the ward environment shortly after a death, and/or by appointment in a hospital mortuary viewing room.

Dedicated research on the practice of viewing is scarce. A small body of discrete evidence derived from the bereaved and originating in countries shaped by Western culture suggested most people who chose to view their adult deceased relative did not regret their decision (Mowll, 2007; Chapple and Zeibland, 2010; Omerov et al, 2014; Mowll et al, 2016). The viewing experience reportedly helped to bring a sense of the reality to the death, together with an opportunity to say goodbye (Mowll, 2007; Chapple and Zeibland, 2010; Harrington and Sprowl, 2012; Mowll et al, 2016). Survey respondents with professional experience of viewing have also expressed opinion that 'seeing is believing' and helpful to a person's recovery from grief (Paul, 2002). Acceptance of the loss is an identified first task of mourning and sets the foundation for working through the pain of grief (Worden, 2018).

It is important to note that within the above-mentioned studies, most deaths were due to unnatural causes, typically homicide, suicide or accident. Viewing also took place at different times and in a variety of settings, for example at the scene, in the hospital, a funeral home or church. Harrington and Sprowl (2012) highlighted perceived differences in the value

of what they referred to as 'early' and 'later' viewings. Early viewing in a hospital was described as assisting the bereaved to confirm the reality and circumstances of the death and later funeral home viewings allowed for final goodbyes.

This study addresses an evidence gap in knowledge and understanding of viewing in a hospital setting in circumstances of a sudden or unexpected death from natural causes. Recognition is given to the family voice as a valuable source of experiential evidence that may help to judge, guide and inform the nature and quality of service provision and care.

Methods

Design

A qualitative, exploratory approach to inquiry was chosen to gather insightful experiential descriptions, and for its suitability when researching a sensitive topic (Silverio et al, 2022). Specifically, the study used Interpretative Phenomenological Analysis (IPA) (Smith et al, 2022); an inductive methodology particularly useful for understanding under researched phenomena (Peat et al, 2019). IPA is committed to the individual lived experience in context, involving meticulous case-by-case analysis before searching for connections across the data set (Smith et al, 2022). A distinctive feature is small and homogeneous samples, sacrificing breadth for depth and detailed interpretative accounts (Smith and Osborn, 2015). Careful consideration was given to ethical issues of importance in bereavement research (Sque et al, 2014). Approval to conduct the study was obtained from the Health Research Authority following review by a National Health Service Research Ethics Committee; reference 22/EM/0069. To enhance rigour, this study adhered to the Consolidated Criteria for Reporting Qualitative Research (Tong et al, 2007).

Context

The study took place in a NHS acute hospital in England. First launched in Spring 2020, the hospital's supported viewing service is based on the Sign, Words, Actions, Needs (SWAN) model of personalised care at the end of life and during bereavement (Stewart-Lord et al, 2022). SWAN has been adopted as a standard of care in many UK healthcare organisations (Stewart-Lord et al, 2022) and this extends to the hospital and mortuary facility which is named The SWAN Suite. The supported viewing service is organised and delivered by a team of three specialist bereavement nurses in collaboration with a multifaith chaplaincy, mortuary assistants, portering staff and a clinical illustration photographer. Chaplaincy support includes the offer of prayer with or without family presence and a personalised prayer card. Personal keepsakes such as handprints, locks of hair, knitted hearts, and a photograph are also offered in recognition of their understood value to grieving families (Neville et al, 2020; Stewart-Lord et al, 2022).

Sample and recruitment

A purposive sample of participants were recruited in accordance with pre-determined inclusion and exclusion criteria. Two specialist nurses for bereavement with access to a database of eligible participants assisted the recruitment process by first enquiring if the family member was willing to receive written information about the study. Of the 74 family members contacted, 58 (bereaved between 01 December 2021 and 30 November 2022) agreed to receive a recruitment pack. The return of a completed reply slip and consent form to the Principal Investigator (PI) confirmed their willingness to join the study. Recruitment closed after the total population of eligible participants had been approached.

Inclusion and exclusion criteria

Inclusion criteria

- Bereaved adult (minimum age 18) who accessed the supportive viewing service following the death of their relative
- Family relationship to the deceased (wife, husband, partner, parent, son, daughter, sibling, grandparent)
- Bereaved no less than 3 months and no more than 12-months at the time of recruitment to the study.

Exclusion criteria

- Situations where a formal complaint about the care service provider is under investigation
- Adult bereaved family members who are known to lack capacity to consent.

Data collection

Semi-structured telephone interviews were used to collect data with the aid of a topic discussion guide. The calls were held in a private room at a mutually agreed date/time. All interviews were completed by the PI; an experienced female postdoctoral qualitative researcher who had no prior relationship with the participants. A pilot interview was carried out to pre-test the research procedures, and with the interviewee's

consent, their data formed part of the main study. Each interview was audio-recorded with the participants' consent and transcribed intelligent verbatim. Interviews lasted an average of 66 minutes. A research journal was used to record post-interview contextual information and written reflections on the researcher's judgements and beliefs. Attention was paid to the potential influence of personal preconceptions, particularly in respect of the double hermeneutic dynamic that is central to IPA (Peat et al, 2019; Smith et al, 2022).

Data analysis

Transcribed data were analysed in keeping with a new development by Smith et al (2022) comprising more explicit descriptors of the process and outcomes of IPA (*Table 1*).

The PI completed steps 1–5, commencing with an idiographic approach and culminating in a synthesised interpretation of participants' experiences. Members of the research team with experience in qualitative research and IPA and a specialist nurse-bereavement contributed to the consensus meeting (Step 6). Participant anonymity was maintained by removing any personal details (e.g. names) at the point of transcription and by assigning a pseudonymised code, i.e. Participant 1 (P1).

Findings

A total of 13 family members provided written consent to join the study. However, three did not proceed; two related to personal wellbeing, and one non-response to contact attempts. The final study sample comprised eight women and two men and represented a range of relationships to the deceased person (*Table 2*). Participants were 5–9 months bereaved at the time of recruitment, the exception being the pilot interviewee whose relative died in 2020. In all cases, the patient died from natural causes, either following a sudden catastrophic illness or where a serious illness was known about, but the death was not expected at that time. All patient deaths were following announcement of the coronavirus (COVID-19) global pandemic in March 2020. In-person compassionate visiting provided an opportunity to view in the place of death, and hospital procedures were tailored to the nature and scale of local outbreaks.

Participants' experiences of the supported viewing service were synthesised to form three group experiential themes, each comprising two to three sub-themes (*Table 3*). In the following section, the study findings are presented under the themed headings, together with exemplar quotes to support data interpretations.

A choice to view in the SWAN Suite

Information and understanding

Participants primarily first came to know about the supported viewing service through the hospital bereavement nurse. Other sources of information included verbal explanation and/or literature provided by ward staff, and in one case, via a friend with experience of the viewing service on offer. However, there was an apparent

Table 1. Analytic process

Single case analysis	
Step 1: Reading and re-reading	Listened/checked the transcript against the audio recording; immersion in the original data.
Step 2: Exploratory noting	Line-by-line analysis of experiential claims, concerns and understandings; areas of interest and preliminary interpretations noted in right hand margin of transcript.
Step 3: Constructing experiential statements	Exploratory comments analysed to develop statements directly related to the participant's experience; statements reflected the participant's original words and the analyst's interpretation.
Step 4: Searching for connections across experiential statements	The drawing together of experiential statements to form Personal Experiential Themes (PETs); consolidated analyses were named and organised in a table.
Repeated steps 1–4 for each individual transcript, followed by cross-case analysis	
Step 5: Working with PETs to develop Group Experiential Themes (GETs) and subthemes	A synthesis of interpretative analysis underpinned by relevant experiential statements from contributing participants. A threshold of at least half of the participants inhabiting each GET determined plausibility.
Step 6: Determine the coherence and plausibility of the thematic interpretations	In collaboration with the research team.
Adapted from Smith et al (2022)	

lack of knowledge and some surprise about the hospital viewing facility.

> **'I tried to ring up [to arrange viewing] and they said, "I'm sorry, but the mortuary is not open." … I didn't know what the procedure was … What happens at weekends? I got hold of [bereavement nurse] and all of a sudden, she explained, this is how you can come and see him.' (P4)**

> **'I didn't realise that you could actually see somebody at the hospital … like the SWAN Suite ... I only thought that you could go to like the funeral home ...' (P2)**

A personal decision and desire to view

Nine participants, of which four had experienced viewing at the bedside, chose to view their deceased relative in the SWAN Suite. The exception was P1 who explained:

> **'I didn't feel the need … I'd had a very intimate last few words with my mum. I said all that I wanted to say to her. I'd felt that I'd said my goodbyes … I'd seen Mum and I'd had affirmation that she was actually dead.' (P1)**

Participants disclosed a variety of seemingly determined reasons for viewing that included a sense of personal obligation and devotion, an end-of-life experience that was not pleasant, images of the deceased person at the time of death, and concern for the deceased person being left at the hospital and alone. Participants spoke of wanting and needing to see their relative again, and for some, there was a pressing need;

> **'I was anxious to see her again' (P2)**

> **'I knew we'd probably be able to see her in the chapel of rest, but I just wanted to see her then …' (P8)**

One participant described the SWAN Suite as 'a bonus' (P10) that afforded opportunity to see his deceased relative prior to arrangements for a direct cremation. Others also saw viewing as an ultimate time together, speaking in the vein of seeing their relative one last time and last goodbyes.

> **'You're never going to feel or touch them again or hug them. That's the sad thing about it really. You think while he's there, he's still flesh and blood, but once they're cremated, they're gone aren't they. You're never going to see that person again. I think that was the main reason why we went … Just to go and see him again … To say your last goodbyes.' (P4)**

Preparation and preferences

When asked about any needs in preparation for viewing, only a few participants elaborated, and their replies mostly concerned practical arrangements such as an appointment date, time and length, parking facilities and location. Two participants said they 'didn't know what to expect' (P3, P5) in relation to the viewing, and some misconceptions and anxieties were evident.

> **'We had it in our head that we were literally going, and she would be pulled out the drawer and that's how we would see her. We didn't realise how it would be … so, it was quite worrying.' (P2)**

Not all the participants could recall being offered the choices of faith-based support and prayer and apparent uptake was reflected in two interviews only. In both cases, prayer and the receipt of a prayer card were valued. A decision to decline prayer appeared to reflect the religious views, beliefs, and practices of the participant and/or their deceased relative. Memory keepsakes, including a lock of hair, a handprint, a photograph, a keepsake box, and/or a matching knitted heart were offered to,

Table 2. Participant characteristics

Participant	Sex	Relationship to the deceased person
1	Female	Daughter
2	Female	Daughter
3	Female	Mother
4	Female	Daughter
5	Female	Daughter
6	Male	Brother
7	Female	Granddaughter
8	Female	Daughter
9	Female	Sister
10	Male	Husband

Table 3. Themes and subthemes

Group experiential themes	group subthemes
A choice to view in the SWAN Suite	Information and understanding A personal decision and desire to view Preparation and preferences
A profoundly personal experience	Intimate and enduring Personal observations and reactions
Hallmarks of quality care	Compassionate, person-centred care Care quality considerations

and accepted by eight participants. These were seemingly cherished possessions, of comfort and sentimental value to family members in their grief.

> **'I've got the handprint … which I look at every day … I've got a knitted heart as well … her lock of hair … You just feel that she's around me still … And when you're first grieving you just want to feel that she's with you … So, it was … really, really helped me through the grieving process, especially the first initial months when things are quite difficult.' (P7)**

A profoundly personal experience

Intimate and enduring

Participants reflected on the moment in time with their deceased relative in the viewing room; a physical and emotional connection of being with and sitting by, of being able to touch and hold their relative;

> **'I sat by her side … I was stroking her hair' (P10), and some had a preference to view alone; 'I wanted some 'me time' with her … I needed to say my own goodbyes …' (P3).**

Most participants commented on the ambience of the environment as contributing to the intimacy of the viewing experience. This was reflected in words such as beautiful, lovely, peaceful, relaxing and calming, and other influences such as quiet music in the background, a lit candle, flowers and a poem about bluebells. Some recalled seeing a knitted heart placed with their relative at the time of viewing and suggested an enduring connection by having the matching heart in their keep.

> **'We had one each [knitted heart] and they'd put it next to her… [Daughter] obviously took hers with her and I've kept mine with some of [her] belongings, so it was still as if we were attached …' (P3)**

> **'They gave me … it was a knitted heart. Red heart. There were two, actually … One they put in [wife's] hand, and the other one I had … And I've still got that heart, actually. And when I go out, nine times out of ten, I put that little heart in my pocket …' (P10)**

Personal observations and reactions

Several participants described their viewing experience as positively different than expected and recalled personal observations of their relative looking at peace or peaceful:

> **'Mum just looked so peaceful' (P8) and presented with care; 'It was lovely the way they'd presented my mum.' (P2)**

Three participants, who subsequently viewed at the funeral home chapel of rest also suggested viewing in the SWAN Suite was important to personal and positive memories of their relative's physical appearance. Natural changes after death and embalming were discussed when comparing early (hospital) and later (chapel of rest) experiences of viewing:

> **'I did go along to see my sister at the funeral directors … However, she was significantly different at that time … I was so glad that I could see her as soon as practically possible after her passing at the hospital.' (P6)**

Overall, participants' emotional responses to viewing were positive. No one spoke of regret. On the contrary, the word glad was often used when reflecting on the choice, opportunity, or decision to view. Participants spoke of gaining comfort and being helped in their grief.

> **'They've helped me so much in a way that through the heartache of losing [daughter]. To leave her the way she was there at the Swan Suite was just unreal … It definitely helped at the time, and it still helps now.' (P3)**

> **'When I walked into that room and saw the way my sisters were lying in the little bed there, oh they looked so pretty. And the whole atmosphere was so lovely … I couldn't emphasise what a difference it made to me … the comfort it gave me was immense. And that memory is a comfort to me now, and always will be.' (P9)**

Hallmarks of quality care

Compassionate, person-centred care

Apparent contributions to the participants' positive experience of viewing centred on the interpersonal relationship between the family member and the providers of care and support. Participants described how they were made to feel special, comfortable and at ease. There were also several accounts that suggested personalisation in response to the family member's needs and requests such as personal clothing, music and opportunity to place items of sentimental value with their deceased relative. Recollections of the care provided were laden with personal attributes such as caring, kind, thoughtful, professional, sincere, and spoke of

empathic understanding, dignity, respect, and trust in care.

> **'She [Mum] was one of the most important people in my life. You want to leave them with somebody that makes you feel that she's the most important person there … That somebody's going to look after her as much as you would look after her, and that's how I felt.' (P8)**

> **'The photographer was professional. It wasn't someone who just takes snapshots with limited experience. It was so delicately afforded and facilitated and respected that it's just so comforting, with a healing type of approach, of empathy and support throughout.' (P6)**

Care quality considerations

When invited to reflect on the quality of the viewing experience, many participants responded affirmatively with expressions of gratitude, praise and commendation. For some, their satisfaction with the supported viewing service mitigated a need to view at a funeral home chapel of rest:

> **'I was quite happy, content and comforted by the last time I saw him with yourselves' (P5).**

Considerations regarding the environment included aesthetic improvement to the entry of the SWAN Suite, and better labelling to help locate the viewing facility. Some participants were concerned that opportunity to view their deceased relative at the hospital may be missed in the absence of people getting to hear about the service. Communication was also discussed in the context of preparation to view and to clarify expectations. Recommendations centred on clear and timely communication, particularly how and when information is shared.

> **'Maybe it could have been explained a bit more how it [the viewing] works and what happens … I think people maybe need to have it in writing because you're in such a daze like a day or two after you've lost them that it doesn't always sink in on the phone what you're being told.' (P2)**

> **'I just hope that somehow … other people get to hear about the service that you offer because it is so comforting … If I'd have found out now that service is available and I hadn't known about it, I'd have been devastated.' (P5)**

Other suggestions for service improvement centred on aspects of care particular to the participant's experience and the personal needs of others who may choose to view. For example, one participant, a devout Sikh, suggested the calming benefits of a Simran prayer when walking into the viewing room. The importance of timely care was also raised by a participant who explained a delay in patient transfer to the SWAN Suite that caused distress and another who described the reduced quality of a handprint as nature had taken its course. There was also highlighted opportunity for personal care of the deceased person in consultation with the family:

> **'… have they got a certain way they want the hair?' (P2)**

This was also combined with a perceived opportunity to assess the family bereavement needs at the time of death and when viewing and to raise their awareness of available support:

> **'Like, how are you? Is there anything else we could do? Well, if you do need us, you can call …' (P2)**

Discussion

This study provided in-depth insights into the lived experience of viewing the deceased person in a hospital setting in circumstances of sudden or unexpected death from natural causes. Sudden loss can leave survivors feeling shocked and confused (Randolph, 2023) and information intake is known to be affected by an unexpected death (Rejno et al, 2013). The findings affirmed the importance of good communication in enabling and supporting a bereaved person's self-determined choice, and to sensitively and adequately prepare individuals who decide to view. The communication skills of active listening and sensitively crafted questioning would seem particularly relevant to ascertaining a person's understanding of viewing. Consideration should also be given to the timing and content of verbal and written information that enables an informed personal decision on whether to view, adequate preparation for those who choose to proceed, and equity in opportunity to experience a viewing service.

Whelan and Gent (2013) draw attention to subtle differences in the practice of hospital viewings dependent on the circumstances and cause of death. For example, viewing for the purpose of formally identifying a person, as may be required following a traumatic/unnatural death, or as evidenced in our study, solely for personal reasons. This highlights the importance

of hospital care after death policies that are built on the principles of personalisation, where viewing care and support is tailored to people's circumstances, preferences and needs. A variety of tools are available to support the initial assessment of a bereaved person's needs and to facilitate ongoing monitoring and evaluation of the service provided (National Bereavement Alliance, 2019). The study findings shed light on best practice standards for a supported viewing service and provide baseline evidence for progressive quality care.

Viewing in the hospital SWAN Suite was an apparent welcomed opportunity for family members to see and be with their deceased relative and to realise a range of personal needs. Some explanations echoed a yearning; an emotional state widely experienced in situations involving loss (O'Connor and Sussman, 2014) and a recognised phase of grief (Bowlby and Parkes, 1970). The brevity of time between the onset of acute/critical illness, deterioration and death may have influenced decision-making, and an important consideration for practice is the seemingly pivotal role of hospital-based viewing in reuniting family members who experience a sudden loss in this way. However, the interplay between reality and viewing, a common finding in previous research, did not materialise in our findings. This is apart from one participant whose visitation and time with their deceased relative at the bedside provided affirmation of death. The importance of viewing the deceased person in the place of death was reiterated in terms of proximity, particularly regarding concerns about physical changes after death or altered appearances due to embalming at a chapel of rest. Like previous study findings, there was a sense of solace attributed to family members seeing their relative at peace (Chapple and Zeibland, 2010; Harrington and Sprowl, 2012) and presented with care (Mowll et al, 2017; Mowll et al, 2022). The role and contribution of hospital mortuary staff to bereavement services and in preparing the deceased person for viewing has been acknowledged (Woodthorpe and Komaromy, 2013). Hospital-based projects have also highlighted the value of improvement to the viewing room upon the memories of people bereaved (The King's Fund, 2011). Viewing in the hospital was described as a time for final goodbyes, either because there was no desire or perceived need to view in a funeral home, or a direct cremation was planned. These perspectives highlighted the significance of the service provider's final acts of care; the end-of-life care mantra of 'one chance to get it right' (Leadership Alliance for the Care of Dying People, 2014).

Prayer rituals at the end of life are an identified source of cultural comfort and support amid loss and grief (Anderson and De Souza, 2021). Prayer was meaningful for, practised by and accepted or desired by a minority of participants in accordance with their preferences, values and beliefs. In contrast, a range of memory keepsakes were offered and accepted by a majority of family members. The value attached to these possessions exemplified participants' interpersonal relationship and connection with their deceased relative, reminiscent of continuing bonds in bereavement (Klass and Steffen, 2018).

The notion of a nurse-led service includes recognition of care that is coordinated and delivered by nurses who have the most day-to-day contact with affected individuals (Khair and Chaplin, 2017). However, teamwork and collaboration are also core components of a clinical nurse specialist (CNS) role (Cannaby et al, 2020). These perspectives featured in the findings of the study in that support was primarily provided by a specialist bereavement nurse, yet reminiscent of a culture of caring and interprofessional contributions to facilitating choices after death (Stewart-Lord et al, 2022) and achieving quality care (Wei et al, 2020). Education and training also feature in the realms of a CNS role, which alongside the sharing of knowledge with other staff, includes self-development (Cannaby et al, 2020). With regard to specialty-specific knowledge and skills, the present study has shown that competence in grief awareness is recommended, alongside effective bereavement communication and cultural understanding of relevance to supported viewings and associated care and support.

Similar to previous observations of support when viewing (Mowll, 2017; Mowll et al, 2022), relational interactions were a dominant theme. A compassionate, person-centred approach to care was revealed and exemplified through meaningful accounts of empathic, considerate care. It has been suggested that the ultimate measure of compassion in practice is the confidence and perceptions of the recipients of care (NHS England, 2013). The value and practice of relational care, together with the quality of care for the deceased person and the ambience of the viewing facility appeared central to a positive viewing experience and personal impressions of support and comfort in grief. The study findings invite researchers to further examine the perceived or measured impacts of

hospital-based viewings on the wellbeing of people bereaved, and family satisfaction with care after death.

Limitations

Recruitment to the study from one acute hospital in the UK may limit the transferability of findings. Participants were self-selected and as such, the study findings may not reflect the opinion of the wider population with experience of the service, or adequately represent social, cultural and religious identities. We acknowledge the role and influences of cultural practices and beliefs in shaping grief and bereavement (Silverman et al, 2021; Park and Halifax, 2021), together with the potential impacts of the coronavirus (COVID-19) pandemic on peoples' thoughts about dying and death (Radley et al, 2024). On reflection, maximum variation sampling, a strategy for phenomenological research (Dahal et al, 2024) would have been helpful to exploring and comparing a more diverse range of perspectives. In particular, the wider selection of participants whose demographic characteristics aligned with the research goals and lived experiences of viewing in circumstances of death from natural and unnatural causes. Despite these acknowledged limitations, the study yielded rich experiential insights and understanding of viewing practices and care.

Conclusion

Caring for a person at the end of life and supporting their bereaved family is a great privilege. The findings of this study suggested that viewing the deceased person is an important part of care after death that is meaningful to people experiencing loss and grief. The knowledge acquired for practice adds to the small body of existing research, informing service provision and improvements in accordance with the expressed needs and views of experiencing family members. Viewing is a personal decision that may be difficult to decide upon for people experiencing grief. The reflective accounts included in this study have the potential to help a bereaved person to make an informed choice about viewing the deceased following the death of a relative in the hospital setting. *IJPN*

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CPD reflective questions

- Consider a time when you have provided care after death. In what ways were the bereaved family enabled and supported to make an informed choice on whether to view their deceased relative?
- Reflecting on the research findings reported in this paper, for what reasons do the bereaved decide to view their deceased relative?
- In your experience, which members of the interprofessional team help to facilitate and support a viewing, and how might a collaborative approach enhance the quality of care?

Key points

- Viewing the deceased person is an integral part of hospital-based bereavement care and support
- Research to guide and support the practice of viewing in a hospital setting is scarce
- In this study, viewing the deceased person was explained as an important part of care after death that is meaningful to people experiencing loss and grief
- Consideration should be given to the supportive role of a specialist bereavement nurse and interprofessional team contributions to viewing practices and care.

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