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**Talking about Bereavement Podcast Series**

**Transcript of ‘Bereavement in remote, rural and island communities: a district nurse’s experience’ podcast episode**

**Presenter:** Dr Clare Tucker (CT), Senior Educator: Bereavement, NHS Education for Scotland

**Speaker:** Jenna Gettings (JG), Advanced District Nurse / Clinical Lead for Skye, Lochalsh and Wester Ross, NHS Highland

**CT:** Hello and a very warm welcome to the Talking About Bereavement podcast, brought to you by the Bereavement Education Programme at NHS Education for Scotland. I'm Clare Tucker from the Education team, and we're so glad that you're here. In this podcast, we're opening up honest and thoughtful conversations about bereavement. We'll be joined by guests who will share their experiences, insights, and the meaningful work that they're doing to support others through grief and bereavement. Wherever you work, across health, social care, or perhaps even beyond, we hope there'll be something here for you.

Hi again and welcome to this episode of the podcast. I'm really pleased to introduce my guest today. We've got a great conversation ahead. And if you find this episode helpful, please consider subscribing, sharing it with a colleague or friend and leaving us a review. Your support helps us to reach more people and keep these important conversations going. Our guest today is Jenna Gettings. Hello and welcome, Jenna, how are you today?

**JG:** Very well, thank you.

**CT:** Great. Thanks very much for joining us. Jenna is an Advanced District Nurse and Clinical Lead for Skye, Lochalsh and Wester Ross where she overseas and supports eight district nursing teams and, serving 12, serves 12 GP practices across some of Scotland's most remote rural communities. Jenna's role involves combining frontline clinical practice with strategic leadership to ensure high quality, person-centred care is delivered to patients in their own homes. Sounds like a fascinating role Jenna, and a really interesting geographical place to work. Tell us a little bit more about how you've got to where you've got in terms of your life and work and the, and the work that you do.

**JG:** Yes, well, I've, I've been very lucky to be working for the NHS for 22 years now, probably nearly 23 actually. I did start and trained in England, but I worked in hospitals for 10 years. Did enjoy it, found it great, great, but it was much more, I found the fact that I could work in the community much more rewarding because I could spend time with my patients and I could also steer my treatment towards what they actually needed. So after 10 years in the hospital, I decided to go out into the community and I was in a rural area of Lancashire at first, but then my husband got relocated so we moved up to Inverness. And when I moved up to Inverness they were very, they didn't have any district nurses. So they were very, very keen for me to train as a district nurse. So I agreed to train as a district nurse and didn't realise that I was going to be a guinea pig for the MSc in Advanced District Nurse Practitioner at RGU, which was really quite interesting, fascinating, difficult, but it certainly gave me a, lots of valuable information and training to do my job.

**CT:** Yeah.

**JG:** I spent eight years in Inverness working in the community there and it was quite fast-paced, lots of information, lots of interesting cases. When COVID hit, I did actually work in the hospital for a little while, at, in Hospital At Night and on the elderly rehab wards, which my DN background came quite useful in…

**CT:** I bet, yeah.

**JG:** especially working in people's homes and knowing what they needed at home. And then while I was doing that, my current job, my current position came available working as an Advanced Nurse Practitioner in Skye, Wester Ross and Lochalsh. I also look after a little island called Raasay in that as well. And I must admit I was a bit unnerved by the actual size and when I first enquired about the job, I said “Where exactly is this and what…” because it didn't quite clearly state exactly how big an area it was. And knowing that I thought well I will give it my best shot and try it. And I think just realising that there's only one me and that I can only do so much, I think was probably my first learning curve in the job.

**CT:** Yeah, goodness, so for people who aren't familiar with the geography, would you like to tell us a little bit more about your patch and, and what some of your day-to-day movements looks like?

**JG:** Yes, well, I actually live not far out of Inverness at Drumnadrochit. So that's actually only about 15 miles out of Inverness, which is our local major city and it's also our local major hospital. But my area covers Wester Ross, which encompasses Ullapool, Gairloch, Applecross, Lochcarron. We also Loch Alsh, which is Glenelg, the Kyle District, Plockton. Then we go on to Skye. So all of Skye basically right from Kyleakin down to the south, Uig in the north, all of Skye and the, Portree, Dunvegan and Broadford, which there is a local hospital there, but they don't do an awful lot of major needs there. So they, they usually get seen in Broadford first and then would have to travel another two and a half hours to Inverness,

**CT:** Yes, yes.

**JG:** if it requires further treatment. We do have a, a hospital in Portree but it is not a, urgent care centre and we tend to have people who are recuperating after a long-term stay in hospital before they can go home,

**CT:** Right, right.

**JG:** there. We unfortunately don't have a lot, a, awful lot of care homes in the area or nursing homes in the area. So quite often people prefer to try and stay at home because the alternative is they could end up in a care home or a nursing home quite some distance away from their family and friends,

**CT:** Yeah.

**JG:** on Skye, for instance, or in Wester Ross.

**CT:** Right, right.

**JG:** So a lot of the people here have been born in a very rural and small community,

**CT:** Yeah.

**JG:** and that's exactly where they want to stay,

**CT:** Yeah, yeah.

**JG:** because they've worked there, they've grown up there, they know everybody in the area. And so, this is exactly where they want to be at the end of life as well.

**CT:** So, some extra challenges there in terms of providing care to people when you've got those geographical considerations about what's available and things. Yeah, as well.

**JG:** Yeah.

**CT:** And I remember when we spoke before you talked about an incredible figure around the percentage of the land in Scotland that your health board, NHS Highland covers.

**JG:** Yes.

**CT:** I don't know if you want to just share that again?

**JG:** That's right. So, the, NHS Highland covers approximately 41% of the, Scotland’s landmass. We don't actually have anywhere near the population of any of the other boards. However, because of the vast distances between, our services are quite few and far between. So, what we can provide is still there, however, you need to be able to travel to it and that can take, like I said before, a good two hours, two and a half hours and it may be that you have to travel by ferry, or, as well as car or public transport to get to those services. So that really means you have to be determined to get to that appointment,

**CT:** Yes.

**JG:** or you have to want to get to, to that treatment, which can put barriers in for people who are in a remote and rural area. And you find that a lot of people are very stoic about their health. So, unless it's, you know, their leg’s falling off, they probably turn around and say, “Oh, it's fine, it's just a scratch” and,

**CT:** Yeah.

**JG:** lets stick a band-aid on it because I don't want to go to the hospital because it's so far away and I've got things to do. So getting those people actually interested in their own care and, and planning for their own treatment can be very difficult because they, they feel that it's… they don't want to put anybody out and they certainly don't, don't want to be travelling out of the area if they can help it.

**CT:** Yeah. It strikes me that in the biography there, when we sort of introduced you, we talked about, well there was reference made to, you know, delivering high-quality person-centred care. And I think person-centred care is the sort of phrase that we use so much, isn't it, in healthcare, but it strikes me that, that is really what you're doing, isn't it? It's, you know, there's no, there's going to be no presumably one-size-fits-all approach in, in some of those remote, rural or island communities. If, if you're seeing someone in the centre of one of Scotland's biggest cities versus some of those remote areas, it, it must be a completely different approach that you need to take in terms of thinking about what's feasible and realistic and what's the weather like. And putting that all together must be, must be exciting and challenging at times, I guess in equal measure.

**JG:** That's right. I think it's a case of, we have to work closely with the patient, find out what's important for them, what their goals are in relation to their treatment. Then we can start working up towards and giving them maybe advice or looking towards what we can offer to support them. Especially things like in end of life we look at advanced care planning, we talk to them about maybe where they would like to be in their end of days and also we discuss with them what we can offer. So do they live alone? Is it easy access if they need support from out of hours? Our district nursing service, care at home, do we need to involve the social workers? In regards to their treatment plan, they might want to be self-sufficient so we have to look at them and say what can you do for yourself? What can family do for you? And we can then offer a plan that makes them self-care for a certain time. That might need to be reviewed on a regular basis as time goes on, they might not be able to do that. And then maybe family might have to take on more of a role if they're willing to do that. Also, it might not be a family member, it might be a carer, it might be a next door neighbour, it could be a good friend. And a lot of the times you find in remote and rural communities and villages that they, these people have grown up with each other and they want to make sure they can support each other to stay and live in that, in their own homes for as long as possible. So, they still have the, they have the same goal as we do,

**CT:** Yes.

**JG:** which is to try and support them where they are. And thankfully usually with, with their support and, and with our guidance, we do have some very successful rates of people being able to stay at home as long as we can feasibly do that. And as long as their, their symptoms are managed and they, they're feeling happy to be there, then that's exactly what we do.

**CT:** Sounds like a real team effort,

**JG:** Yeah.

**CT:** with both your expertise and the patients themselves knowing themselves and, and the support that they have around them. I suppose if we think sort of a bit about the bereavement context, which is obviously where we come from, particularly with this podcast, if we think about sort of how we support people in remote and rural areas who are bereaved or anticipating bereavement or anticipating loss, what can we do to support people well in those, in those contexts you think from your perspective and your experience of, of working where you do?

**JG:** Well, like I said before, I think I touched on it, we look at advanced care planning. So we will talk to the family in their own environment and the patient, and we will probably trigger some of those very difficult discussions about the fact that they're becoming unwell or they, their actual health is deteriorating. And if they do, would they want further treatment? Do they want to go into hospital? And I think that's quite a difficult one because sometimes it's a case of you have to advocate for the patient, but it might not be what the family want to hear. So, I've had patients that are diagnosed with a, a palliative condition and we were treating them regularly for chest infections for instance. However, the family kept on phoning up the GP and saying we need some more antibiotics for this chest infection, it's come back. And the lady herself had had started to stop eating and drinking and had, her consciousness level wasn't actually improving. So I sat both the husband down and the son down and was explaining to them that even if we got the antibiotics for the chest infection, she was unlikely to be able to take them, and secondly, it wouldn't actually improve the outcome even if she did take the antibiotics because unfortunately that process of dying had started. And I think sometimes it's very difficult, if you can broach it with the family and the patient before it happens, it's great, but sometimes they don't want to hear it until it's actually in the process.

And a lot of people don't understand the process of death and dying when it starts because it's very subtle. Some people will be bright one day and want a cup of tea and have some soup, and then the following day they'll sleep all day and have not had any interaction with any of their family. And I think some people want to make sure that they're doing everything they possibly can. So feeding them a bit of water or trying to get them to eat, they think they're doing something and it's explaining to them that they actually, the body is doing exactly what it needs to do. And if they don't want to take it or they're not asking for it, then it's not required. And I think getting people to understand that is a good start on the process of understanding that this person is on, on the last few days of living. Quite often when we're there in the home, we do explain to them what, how the patient's progressing and, and what to do if there's any pain or symptom control. And explaining to them that if they feel that they need help and support, then they need to contact us as soon as possible because we may be with another patient. Or if it's out of hours, we may need to travel some distance to get to them. And we wouldn't want them to delay symptom control any longer than possible. So we explain to them that we are there on-call. This is something we only do really in the remote and rural area that I'm in because in the towns and cities we do actually have on-call staff that are able to do this for us. But in the remote area, rural areas where we are, unfortunately, there isn't really an awful lot of medical support. So we will, when it looks like people are requiring symptom control overnight, then we will go on-call as a district nursing team. And the advantage of that is that we know the patient's history, we know what medication they're currently on, and we usually have had some dealings with them that day. So we, we have an idea about what their condition is before we're going into the night. So if the family phone up and say we need support, then, then we've got the background already so we can just go straight away.

**CT:** So there's a real continuity there, as you were talking about, about being on-call and overnights and how that might be different to other areas, there's a real continuity of practice and, and that must be a real, a real gift in some ways, to be able to have that understanding of, of the person and their family and their setup so that you're not perhaps in the middle of the night going into a scenario where you're less familiar with the person or haven't met them before, and how that must be, I can see quite different to some of the other sort of geographical areas, or towns and cities, as you mentioned, and how other people might be working.

**JG:** I think we're really lucky in, in district nursing that not only do we get to know the patient themselves, but we get to know the family, the friends, the, the way that they live, their lifestyle, how they've lived before when they were younger, you know, what kind of achievements they made in their life, just, the whole person, not just that person in the hospital bed, we, we get to find out. And a lot of us have known these people, if we worked in the community for a long time, we've, we've known them and work, worked with them in the community or been to celebrations within the community and, and we are part of that community. So we do an awful lot of support with them, but they often know our friends, our families, our children. So, so the, it's a kind of, maybe a bit of, a relief and support to know that there's somebody there that they know so intimately,

**CT:** Yeah.

**JG:** and they're coming into their home, so it's not seen as a stranger. We're probably seen more as a part of the community,

**CT:** Yes.

**JG:** and the more that we interact with them, probably think that, you know, I mean most of us, they find out all of our, our family ins and outs because it's one of those things, you have a conversation about and they say, “Oh well, you know, so and so's passed their driving test” and “Oh well, my grandchild's done this”. And so it's a really nice conversation when you go in, it's like meeting a new friend and we might be the only people they see for a day or two. So it's nice to have that different conversation from just the pure medical reason we're in.

**CT:** Yeah, yeah. And I can see there you’ve sort of highlighted all the benefits for the patient side of things in terms of them having a familiar face, I suppose it's just making me wonder what it's like for a staff member as, as someone who might be living and working in the same community and perhaps even particularly thinking about that bereavement stage. So, you've sort of talked about a scenario where someone might be approaching the end of their life, and perhaps after that person has died, what is it like as a, or can you tell us the sort of experiences of others that you've heard of who live and work in, in the same community and perhaps bumping into somebody in their local shop or the post office and, and, and is that difficult as a sort of person that lives and works in the same community? And are those boundaries that you, between your life and work blurring? And is that, is that hard to deal with? Or is that just the sort of feeling of what those sorts of communities can be like? And it's, and it's not tricky?

**JG:** I think we do have to compartmentalise our lives. So, when you see us out, out and about, you know it, we'll never really talk about work if it's out and about in the community. We might get asked things about it but obviously we do explain to people that, you know, if it's of a sensitive nature, we're not going to be able to, to discuss that due to GDPR. But most people are aware of what we do and are not going to be asking us that sort of thing. And so that's quite good that they already have that awareness, and I think if you draw that line from the beginning, then most people are aware of it and understanding of it, of course, that it's part of your job, and we do have a, a personal and a professional life.

I won't say that the, the boundaries don't get blurred because if you know of somebody who is unwell, a lot of my staff, if they know that somebody is unwell, will always go above and beyond probably to make sure that that person and is supported and that they don't have to go into a hospital. I think the difficulty for the, for a lot of my staff is that if it becomes extremely personal, so it's a family member, you know, a husband, a mum or dad, a sister, brother, nephew or niece, that is when it becomes tricky because we're in a position where we, we know sensitive information about this person. We know how their condition could ultimately deteriorate and go downhill. And it's a case of, we have to make a decision. And it's usually the, the staff member who would, says “Yes, I want to be involved because I feel I've got, I can manage that” or they'll turn around and say “No, I don't want to be involved because I want to be a family member, and only a family member for that particular person”. And I think either way is absolutely fine because some people want to be there and they want to be in it and they feel that they, they would miss out or they would not be doing what they wanted to do for their loved one if they weren't involved in their care. But at the same time, there's others that, they say, well, no, this is my personal life. And that, the fact that this person is in my personal life means that I want to be a wife, a mother, a daughter or, you know, husband or father. And so they take on that role and, and both of those roles are right. And it's very difficult, I would say, to actually split those two roles. And a lot of the staff do struggle with that because they can see things that need to be done, but they want to hold themselves back or maybe they want to offer help and advice to other family members when they're doing personal care or support.

And a lot of time, that's the difficulty, is other family members will actually look towards us as the fountain of all knowledge, whereas we're still going through the same grief process or bereavement process, that, or the distress of seeing somebody going through the end of life or palliative care than anybody else. Although we do understand what's happening and we do have, that, that knowledge is sometimes a good thing, but it's also a double-edged sword because people will expect you to go, oh, why, why are we doing this? What are we doing this for? So, I think it's up to the individual, and as a manager, I quite often sit, sit the person down and talk to them about how they want to manage this. And any way I can support them in that process is probably the best way to go about it, because they've always thought about it. If they have a family member, they've already gone down that road and they've already understood about where this could go. So, bringing that subject up is very, although it might be difficult, it usually they've got their own answers for it, and they understand what, what they want and what they need.

**CT**: Yeah, absolutely. Well, it's great that you can provide that sort of, again, it's about the person-centred approach, but I was thinking about the sort of you and your, your managerial position and, and looking after staff and their wellbeing in, in that context too I guess. No, that’s fascinating.

You said a lot already about sort of how we do this well. I wondered if there's anything that you've not shared that you'd like to in terms of a, sort of, specific ways that, that you offer support in, in bereavement to families and carers, in those remote contexts, and anything else that you'd like to mention? Particularly, I suppose about the sort of period after a person has died and what your work might involve.

**JG**: Well, for me, I think we offer a particular insight, so I've already said about what we would do to, to talk to people beforehand. And I think we also need to explain to people what might happen when people die. So, I always sit people down and explain that there is a chance that somebody could pass away at home within the next day or two. And I explain to them that the urge to phone 999 or to start panicking as soon as that person's passed away, that they don't need to do that. They, you know, if they've got their family or they've got loved ones and carers in the, in the room at the time, that's the most important thing. If they've got support, that's great. And that there's nothing in that immediate time that needs to be done. They can just sit there and be there with their loved one that's passed away. And I think that gives people a lot of sense of relief that they realise they don't actually have to do anything immediately. Most of the patients that we have at home are expected deaths and as nurses who on-call or during the day, we do extended roles to go and verify that person has passed away. So the GPs don't tend to go out as much unless there's a certain reason why we can't attend. So, it's good that we can go to that person's house and see the family, talk to the family. Quite often we have a discussion about their last moments, how it was. A lot of families express the relief that they were able to be at home, that they were comfortable and that they got what they wished for, which was to die at home in their own, in their own home with their family.

So there's a lot of positive things come out of that visit. And also, I feel that sometimes it's the relief when the patients die that they know that this is final and they're not suffering anymore. And then we talk about the fact that we can support them in giving them a final wash, making sure they're, you know, suited and booted and presentable if any of their family or friends want to come and see them at home. And I think that for some people, they think, “Oh no, we don't want you to touch them”. And we say, “Well, no, it's fine. It's still that person. They're still your loved one”. So, we will give them a full top to toe wash, make sure they're in a nice set of pyjamas or a dress, whatever they want them to be put in, make sure that they're clean. And that if they do, if the family members do want to come and see them, that they are, you know, there's no signs of distress or any signs of the immediate death that might disturb somebody.

So, so that, that's they, they look like they're, the person may be asleep. And we say to them that, you know, you can, you can have the person at home as long as you wish and you don't have to rush to call the funeral director or anything like that. And I think having somebody like myself explain that gives them a sense of relief that they don't have to immediately rush around. We do explain to them about picking up the death certificate and, and what that would need. We do have a few patients that require going to the procurator fiscal and that's usually around things like mesothelioma. And so, they have to be reported and usually they know beforehand whether they're going to need the body for a autopsy to confirm the mesothelioma or other recordable diseases that require reporting to the procurator fiscal and the family are usually aware of that, but it's always good to explain the process. They usually know about it, but it's, it's good for, to just remind them.

**CT**: Yeah, absolutely. It's fascinating thinking, I suppose, about that confirmation of death visit because I think in some ways when I'm sort of previously thinking about that as a task for a, a team to do, it's easy to think of it as a bit of a sort of tick box exercise. But actually, you being in that home, obviously undertaking that task is important, but it gives you a, a huge opportunity as well to do some of those wider things that you were talking about there and helping that, that family as they're just experiencing their first moments of, of bereavement and starting to, to process that. And what a wonderful opportunity actually, it, it gives and how wonderful to, that, you know, that you're actually in their space and can see how they're, they’re managing and, and respond to their questions as they come up. That's, you know, that's, that's really valuable.

**JG**: Yeah, I think, I think I, I, we do tend to give them some space obviously after they, the initial death, but we then plan a week or two afterwards to contact them, the family or carers and ask them if they want a bereavement visit.

**CT**: It must be so reassuring seeing you again. I think I just imagine scenarios where you've got to know families so well and you've been in so much, it's lovely to hear that there's an opportunity for you to visit again after the person has died. And I just wonder, is it hard to protect the time to do that given the caseloads that you're managing? Is there pressure on those sorts of bereavement visits to be, you know, dropped if the day’s looking too busy? Or is that really something that your team's able to, you know, prioritise and, and hopefully not let, let it fall off the ‘to-do’ list for that day?

**JG**: I think, yeah, I think it, we do prioritise it, but I think it's more to do with the fact of, quite often we have a lot of pressure at certain points in the day. So we know not to organise those visits for say, the morning. And this is something that we can do in the afternoon or the end of the day, so that we know we've got that time, so that we can give that family our time. And we have, and the advantage of being in a district nursing service and within the community is that we do have that time to sit with the patient or family and give them our time. It is difficult, I would agree, because there's always going to be competing pressures on our time. But I see it as a very important, and a very necessary part of the job to support them. Because if, if you don't, there, sometimes you find that the patient's relatives become unwell themselves and they've never really recovered from their bereavement. And, and it may be that they, we're not going to be enough for them. So we can signpost them…

**CT**: Yeah.

**JG**: to other support, but we're maybe the stepping stone to that start of a journey for them. And they know that they can see us, and they can speak to us outside. It's saying, “Oh, hello, how are you doing?”. And in in a nicer or a positive environment rather than all, all about, you know, the palliation of their loved one.

**CT**: Yeah, absolutely. And I suppose linking to that in terms of having time, I was sort of reflecting recently about staff attending patient or client funerals. It's, and I think that different people have got different perspectives on what's right for them. And obviously families will have their own thoughts about what's right for their family and, and things as well, whether it's something very small as a sort of ceremony or ritual, or whether it's something that they're, you know, keen to welcome a broader number of people to. But are there particular things you'd reflect on in that kind of remote and rural context about perhaps staff attending funerals for, for people who perhaps were a patient, but maybe also a member of their community? And is, are there differences do you think to, to working in other places?

**JG**: I would definitely say that in the remote and rural communities, you, I do think that there is an awful lot more likelihood of the staff attending patients’ funerals. And it probably isn't to do with the fact that they were a patient of ours, but that sometimes does happen. It's more to do with the fact that they've known them outside of work and they, a part of the community or they have known them in a personal perspective before they've become a patient of ours. And so again, that's closure for the staff themselves, is to say goodbye, have, have the send-off. And I think it also shows the community that we are still part of the community as well as a professional. I know that it probably makes us feel a little bit more human as well. The fact that we can go there and there are people in states, various states of grief, from, if we feel that we need to grieve, which quite a lot of the, there has been times when I’ve felt that I needed to grieve for somebody, then I think it's a good time to do that and show them that you are actually human as well. I think we've all gone home and held it in and then had, had a good old cry, but it's possibly not the healthiest environment. So to have support from your team, the staff and also sometimes the, the patient's family are, are strong for, for you as well. I, I think that that that's a really good closure for the patient, the family and yourself. It, it’s very therapeutic in in some ways.

**CT**: I think that leads beautifully on to sort of where I was going to take us towards the end of the, the conversation this morning, was just about your wellbeing really, and thinking about you particularly and, and others in similar roles, recognising the challenges of the work that you do, and it must be busy and, and, and, and seeing, you know, patients and families at all different stages of the life course and, and bereavement being part of that. You know, how do you keep yourself well in doing this work and keep motivated to continue to deliver such good care to people?

**JG**: I've got to say I, I love being out and about in the community. I work in, I'm very lucky to, even though it's quite a large area, it is a beautiful area. The people are wonderful. They are so different and so unassuming, very friendly. And I think that just being part of their lives for even a short amount of time, I feel very humbled about that. And if I can do a really good job or if I've figured out a way to improve their state of living ability at home, then I feel that I've done a good job and I can go home and go, yes, that, that that is a, an issue that has resolved. I, I do, it's kind of like a puzzle where all the pieces, you have to fit them all together and you have to work with allied care health professionals, my team, other members of staff, maybe third party sector agencies in order to provide the support for the individual and the ability... when you get that working correctly and you see somebody being able to live, it may be independently with support at home for that little bit longer that they have, I think that's, that's, that's a reward in itself. I think as well having a strong family bond at home, going home and being able to say, “Oh, that was, that was a hard, hard day, but I'm glad I've got you to come home to”,

**CT**: Yeah.

**JG**: I think, I think that that kind of, is nice to be able to, if you feel that you need to talk about your own feelings and just feeling like, oh, that was a, that was difficult that was or actually today was a really good day. I, I felt like everything went well. So, to share those, the ups and the downs, I think,

**CT**: Yeah.

**JG**: I think that, that's, everybody needs something like that at the end of the day to decompress.

**CT**: Absolutely. Yeah, absolutely. Absolutely. Oh, it's been so good to talk to you, Jenna. Thank you. It's been really fascinating to hear about your work and I, I'd love to spend a, a day in your car driving around and seeing all the things that you see in terms of the scenery and, and things. I think it would be a, a beautiful place to work. So yeah, thank you so much for joining us, it's been great to talk to you.

**JG**: Thank you for having me.

**CT**: If you'd like to listen to more episodes of this podcast, you can do so on Podbean or Spotify. Just search ‘Talking about Bereavement’. Or if you'd like to find out more about the NES Bereavement Education Programme or have any questions, please do get in touch, or check out our Support Around Death website at [www.sad.scot.nhs.uk/podcast](http://www.sad.scot.nhs.uk/podcast).

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For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or contact [supportarounddeath@nes.scot.nhs.uk](mailto:supportarounddeath@nes.scot.nhs.uk)

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