Advances in Social Work Welfare and Education:
Social Work in a Climate of Change

ADVANCES IN SOCIAL WORK & WELFARE EDUCATION

Implementing a Bereavement Follow-up Program in Hospital Emergency Department

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Abstract

In recognition of the fact that traumatic or sudden deaths in the hospital emergency department can be a distressing experience for families, we piloted a follow-up bereavement service for relatives confronted with an unexpected death. Bereaved families were forwarded a personalised condolence card including the contact details of a social worker to allow them an opportunity to discuss any outstanding concerns about the death. Referral options were provided to relatives requiring ongoing support. Data were collected on the number and nature of follow-up calls, including requests for additional information about the death. Lessons learnt from the pilot were that assessments of each family's situation and the circumstances of the death are crucial before initiating contact. Interpersonal violence and complex family dynamics are compounding factors that may contraindicate follow-up. Rather than adopt a standardised approach, bereavement follow-up in the emergency department needs to be tailored to the circumstances of each family.

Keywords: *Emergency departments; Hospital; Death; Family; Bereavement; Social work*

Introduction

Approximately 5,500 people died in Australian hospital emergency departments (EDs) in 2021-22, with another 2,000 pronounced dead on arrival (Australian Institute of Health and Welfare [AIHW], 2022). Deaths in ED are a regular occurrence and often sudden or traumatic (Ito et al., 2022). A sudden death, such as when a resuscitation attempt is unsuccessful in the trauma room, can be a highly distressing experience for families. Upon hearing of a death, families often experience intense reactions which are moderated by social, cultural, and interpersonal factors (Berbís-Morelló et al., 2019). In cases of criminal offences or accidents, the presence of police in the ED may be an additional stressor for bereaved relatives. Yet, contact with the family in ED is typically a short, intense one-off event (Merlevede et al., 2004). Families may be too distressed at the time of the death to ask questions or, even when provided with an explanation, fail to comprehend its meaning due to shock (Parris et al., 2007). As a result, family members may be left with many questions after an unanticipated death (Berbís-Morelló et al., 2019; Ito et al., 2022; Merlevede et al., 2004; Parris et al., 2007).

The ED is a busy and, at times, chaotic environment that focuses predominantly on providing acute and trauma care (Ito et al., 2022). It can be a challenging space for patients and their families to navigate when seeking medical care and, in the event of a death, is not an optimal environment for provision of post-bereavement support (Bayuo et al., 2022). Environmental factors such as a lack of privacy and noise are additional stressors for bereaved families (Ito et al., 2022). Although ED social workers do provide immediate emotional and practical support to bereaved relatives, typically their involvement with the family ceases when families leave the hospital. These social workers may have to also contend with competing crisis presentations, compounded by increasing numbers of people presenting to the ED with complex needs.

While recognising that grieving is a normal response that is unique to each person, the importance of offering support to bereaved family members is underscored by the risk for prolonged grief reactions in the event of a sudden death in the ED (Cooper et al., 2020). Factors that increase the risk of a severe or traumatic grief reaction include a violent death or a family member's belief that he or she contributed to the death in some way (Boelen, 2020). Personality factors (such as attachment anxiety) and relational dynamics (such as a conflictual relationship with the dead person) may also exacerbate emotional distress (Boelen, 2020). In view of these factors, ED clinicians are increasingly recognising the importance of offering bereavement follow-up to families (Boven et al., 2022; Cooper et al., 2020).

Existing research suggests that families who experience a bereavement in the ED value follow-up that incorporates timely information provision, contact with a health professional who is attuned to the bereaved person's needs, and the opportunity to clarify concerns relating to the death (Cooper et al., 2020; Ito et al., 2022; LeBrocq et al., 2003; Parris et al., 2007; Williams et al., 2000). Notably, few studies have examined the bereavement experiences of relatives after the death of an older family member in the emergency department, with most studies focusing on parental bereavement after the death of a child or baby (Jang & Choe, 2019).

Social workers have identified the importance of end-of-life care in the acute hospital setting, including preparing family members for the death and providing emotional and practical support to bereaved family members (Bateman, 2015; Moon & McDermott, 2020). Bereavement programs are now well established in hospital-based palliative care, with social workers playing a key role in memory making, facilitating viewings of the dead person, and remembrance ceremonies (Silloway et al., 2018). The need for hospital social workers to adapt their bereavement support in line with hospital guidelines for managing the impact of COVID-19 has also been highlighted (Fox et al., 2021). However, most of this literature does not pertain specifically to bereavement follow-up in the fast-paced and crisis-prone environment of the ED where sudden death is a common occurrence.

An integrative review of 47 studies on in-hospital bereavement services concluded that bereavement follow-up is conducted in an ad hoc manner, often constrained by limited resources (Boven et al., 2022). In ED settings, commonly reported services include follow-up telephone calls to families, sending condolence cards or letters, and meeting with bereaved relatives (Boven et al., 2022; Cooper et al., 2020; Williams et al., 2000). The timing of follow-up tends to be variable, ranging from a few days to 12 months after the death. While few of these services have been formally evaluated, findings from existing evaluations are mixed. Several studies indicate that family members appreciated receiving a condolence card or letter, with other research indicating that relatives did not feel routine follow-up was necessary (Boven et al.,2022). One Australian ED that initiated follow-up telephone calls to families found this to be time consuming and, while most families were appreciative of the contact, some perceived the call to be invasive or inconvenient (LeBrocq et al., 2003). Accordingly, a blanket approach to providing bereavement care should be avoided (Boven et al., 2022).

The pilot

In recognition of the needs of family members confronted with an unexpected death of an adult family member in the Emergency and Trauma Centre (ETC) at The Royal Brisbane and Women's Hospital, a social-worker-led bereavement follow-up program was piloted for 12 months. Conceptualised as a quality improvement activity, the program aimed to ensure that families of patients who died in the ETC are provided with the option of follow up support and information after the death. An ethics exemption was granted for this project by the hospital's human ethics committee. This hospital is a large metropolitan adult hospital that sees more than 77,000 emergency presentations a year. Along with providing medical care, the ETC provides a 24-hour social work service which responds to the psychosocial needs of patients and families, including supporting families in the aftermath of a sudden death.

Following a death in ETC, a designated social worker would send the primary family member a personalised, handwritten card including her contact details. Typically, the card was sent four weeks after the death as it was anticipated that in the immediate aftermath families would be busy attending to practical matters. The purpose of this card was twofold: first, to convey a message of condolence; and second, to inform the bereaved family member that follow-up telephone support was available from a social worker.

A handwritten card was favoured over a conventional condolence card as this allowed the wording to be adapted to the circumstances of the death and the perceived needs of the family. The decision to provide the option of telephone support rather than 'cold calling' bereaved relatives was due to concerns that an unexpected telephone call could be viewed as intrusive or even heighten distress.

Family members who initiated telephone contact were provided with the opportunity to discuss any outstanding concerns or questions they had about the death. If the caller requested further information about the death or clarification of medical care, arrangements were made for a member of the medical or nursing staff to consult with the family member. For those bereaved relatives assessed as requiring ongoing support, information on referral options was provided.

The program was piloted for 12 months. During this time, the social worker collected data on the number of condolence cards sent to families; the telephone contact rate; the number of requests for further information about the death or medical care that took place; and number and type of referrals made to other services for follow-up counselling. Data were collected on the nature of telephone calls made by family members, the outcome of the call, and any feedback they provided on their experience of receiving follow-up support. Informal feedback was also sought from ETC Staff regarding their overall perceptions of the program.

What we learnt

Over the course of the pilot, 85 deaths were recorded in ETC with 65 cards forwarded to family members. Ten family members contacted the social worker after receiving the card. All expressed their appreciation for the card, with three sending a thank you letter or card to hospital staff. The deaths experienced by these families were sudden, as is typically the case in the emergency department. Cause of death included cerebral vascular accident, cardiac arrest, acute respiratory failure, intracerebral haemorrhage following a fall, and accidental self-injury.

The circumstances of these families varied. For example, one family member witnessed his partner having a cardiac arrest at a party, while another described the death of a sibling with mental health issues in the family home after an altercation. Similarly, the reasons family members gave for contacting the social worker varied. One family member telephoned for the specific purpose of finding out the time the patient had died, as this had been weighing on her mind since his death. Other family members requested to talk to medical staff to find out more information about the circumstances of the patient's death. Social isolation, care needs, and domestic violence were other concerns raised by family members in the context of their relationship with the person who had died. Brief telephone counselling was provided to several callers and practical assistance was provided to one bereaved family member who presented in person to ETC. Referrals to community services were made for those family members assessed as needing follow-up.

While most families did not initiate contact with the social worker, this outcome is not surprising given that most people do not seek formal support after a death. This finding aligns with other studies on bereavement follow-up in the ED (LeBrocq et al., 2003; Parris et al., 2007). A key principle underpinning bereavement follow-up is to provide family members with the option of further support and information once they leave the ED (Cooper et al., 2020). Whether they elect to take up this offer is their choice. Nonetheless, it cannot be ruled out that some family members may have been experiencing a debilitating grief reaction that prevented them from contacting the hospital (Parris et al., 2007). Alternatively, it may have been the case that these families were already receiving support from community-based bereavement services.

A further consideration is the literacy level of the family members who were sent cards and whether those with limited ability to read English were able to comprehend the written message. In addition, there are cultural differences in condolence-giving with reference to the social context and politeness norms (Koopmann-Holm et al., 2021). Accordingly, it cannot be assumed that the condolence message conveyed in the cards resonated with all families.

Notably, a decision was made to not send cards to 20 patients' families because of limited details about next of kin or because of evidence of conflictual or disharmonious family relationships. Another consideration included concerns about the mental health of the next of kin if they were receiving acute mental health treatment at the time of the patient's death. In these cases, the key consideration was whether forwarding a card to bereaved family members may be inappropriate or even heighten distress. The potential to do harm emerged as one of the key learnings from the pilot as it became apparent that the circumstances of each patient's death and the family situation required careful assessment before sending a card. The following case scenarios constructed from an amalgamation of family presentations demonstrate this dilemma.

> *The wife of the patient disclosed a long history of domestic violence to the ETC social worker and admitted to feelings of ambivalence about her husband's death.*
>
> *The patient who died was divorced and estranged from his adult children who indicated that they had not been in contact with their father for many years.*
>
> *The patient's daughter, who presented to ETC after her mother died, stated that she had been in care as a child and vehemently expressed her dislike of social workers.*

In these situations, the designated social worker first consulted with a colleague to discuss the potential consequences of reaching out to bereaved relatives who may harbour ambivalence towards the dead family member or react negatively to contact from social work agencies. From an ethical perspective, this accords with the principle of respect for persons which encompasses "the duty to avoid doing harm to others" (Australian Association of Social Workers [AASW], 2020, p. 9).

Although no formal data were collected on ETC clinicians' perceptions of the program, medical staff reported appreciation for the cards and notes they received from families. Notably, these clinicians' engagement is key to the sustainability of the program as it requires them to communicate the circumstances of each patient's death to the social worker coordinating bereavement follow-up.

Conclusion

The importance of bereavement care is increasingly recognised in hospital emergency departments and social workers play a key role in supporting families in the immediate aftermath of a death. While providing ongoing support to families is typically beyond the remit of ED social workers, sending bereaved families a personalised condolence card has both symbolic and practical value as it signifies compassion and provides families with an opportunity to clarify any concerns about the death after leaving the hospital. At the same time, our experience suggests that adopting a standardised approach to bereavement follow-up is not advisable and that, in some circumstances, it may not be appropriate to send the family a message of condolence. Where interpersonal violence, estrangement or conflictual relationships are evident, the potential to do harm must first be considered and weighed up. Accordingly, the decision to initiate contact with bereaved family members should be informed by a careful psychosocial assessment of the circumstances of the death and the family situation.

References

Australian Association of Social Workers (AASW). (2020). *Australian Association of Social Workers code of ethics 2020*. https://aasw.asn.au

Australian Institute of Health and Welfare (AIHW). (2022). Emergency department care 2021–22. https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

Bateman, V. L. (2015). Ethical decision maker or "champion" of the dying and bereaved?: The contribution of the hospital social worker to end-of-life and bereavement care. *Grief Matters, 18*(3), 58–63.

Bayuo, J., Anago, E. K., Agyei, F. B., Salifu, Y., Kyei Baffour, P., & Atta Poku, C. (2022). "Resuscitate and push": End-of-life care experiences of healthcare staff in the emergency department – A hermeneutic phenomenological study. *Journal of Palliative Care, 37*(4), 494–502. https://doi.org/10.1177/08258597211050740

Berbís-Morelló, C., Mora-López, G., Berenguer-Poblet, M., Raigal-Aran, L., Montesó-Curto, P., & Ferré-Grau, C. (2019). Exploring family members' experiences during a death process in the emergency department: A grounded theory study. *Journal of Clinical Nursing, 28*(15-16), 2790–2800. https://doi.org/10.1111/jocn.14514

Boelen, P. A. (2020). Traumatic grief following traumatic loss: Nature, correlates, and treatment. *Grief Matters, 23*(1), 14–19. https://doi.org/10.3316/informit.439421379808583

Boven, C., Dillen, L., Van den Block, L., Piers, R., Van Den Noortgate, N., & Van Humbeeck, L. (2022). In-hospital bereavement services as an act of care and a challenge: An integrative review. *Journal of Pain and Symptom Management, 63*(3), e295–e316. https://doi.org/10.1016/j.jpainsymman.2021.10.008

Cooper, J. J., Stock, R. C., & Wilson, S. J. (2020). Emergency department grief support: A multidisciplinary intervention to provide bereavement support after death in the emergency department. *The Journal of Emergency Medicine, 58*(1), 141–147. https://doi.org/10.1016/j.jemermed.2019.09.034

Fox, M., McIlveen, J., & Murphy, E. (2021). Death, dying and bereavement care during COVID-19: Creativity in hospital social work practice. *Qualitative Social Work: Research and Practice, 20*(1-2), 131–137. https://doi.org/10.1177/1473325020981074

Ito, Y., Tsubaki, M., & Kobayashi, M. (2022). Families' experiences of grief and bereavement in the emergency department: A scoping review. *Japan Journal of Nursing Science , 19*(1), e12451–n/a. https://doi.org/10.1111/jjns.12451

Jang, K., & Choe, K. (2019). Bereavement experiences after the unexpected death of an older family member in the emergency department. *International Emergency Nursing, 42*, 7–11. https://doi.org/10.1016/j.ienj.2018.10.006

Koopmann-Holm, B., Bruchmann, K., Fuchs, M., & Pearson, M. (2021). What constitutes a compassionate response? The important role of culture. *Emotion, 21*(8), 1610–1624. https://doi.org/10.1037/emo0001007

LeBrocq, P., Charles, A., Chan, T., & Buchanan, M. (2003). Establishing a bereavement program: Caring for bereaved families and staff in the emergency department. *Accident and Emergency Nursing, 11*(2), 85–90. https://doi.org/10.1016/S0965-2302(02)00210-2

Merlevede, E., Spooren, D., Henderick, H., Portzky, G., Buylaert, W., Jannes, C., Calle, P., Van Staey, M., De Rock, C., Smeesters, L., Michem, N., & van Heeringen, K. (2004). Perceptions, needs and mourning reactions of bereaved relatives confronted with a sudden unexpected death. *Resuscitation, 61*(3), 341–348. https://doi.org/10.1016/j.resuscitation.2004.01.024

Moon, F., & McDermott, F. (2021) Social work end-of-life care interventions for patients and their families in hospital, *Australian Social Work, 74*(3), 276–293. https://doi.org/10.1080/0312407X.2020.1717561

Parris, R. J., Schlosenberg, J., Stanley, C., Maurice, S., & Clarke, S. F. J. (2007). Emergency department follow-up of bereaved relatives: An audit of one particular service. *Emergency Medicine Journal: EMJ, 24*(5), 339–342. https://doi.org/10.1136/emj.2006.042671

Silloway, C. J., Glover, T. L., Coleman, B. J., & Kittelson, S. (2018). Filling the void: Hospital palliative care and community hospice: A collaborative approach to providing hospital bereavement support. *Journal of Social Work in End-of-Life & Palliative Care, 14*(2-3), 153–161. https://doi.org/10.1080/15524256.2018.1493627

Williams, A. G., O'Brien, D. L., Laughton, K. J., & Jelinek, G. A. (2000). Improving services to bereaved relatives in the emergency department: Making healthcare more human. *Medical Journal of Australia, 173*(9), 480–483. https://doi.org/10.5694/j.1326-5377.2000.tb139300.x