Problem:
For the loved ones of many patients, the only thing that they receive after the patient dies is a bill. A Bereavement Program providing follow-up support for survivors had not been established.

Evidence:
Bereavement programs have been a significant and important component of Hospice and Palliative programs both nationally and internationally and have been demonstrated to be of benefit to the survivors of patients who have died.1,2,3,4,5,6 However, the content of Bereavement programs has varied and may include such diverse elements as cards, calls, counseling programs, grief services and grief resources1,2,3,4,5,6. Methods of evaluating the success of these programs may also be variable3,4,5,6.

Strategy:
A 225 bed hospital affiliated with an academic center has been developing and expanding a Palliative Care program to meet the needs of a diverse group of patients, including oncology, geriatrics and general medical/surgical patients with irreversible healthcare conditions.

Although some of these patients live for several weeks to several months, the trajectory of their conditions almost invariably culminates in death. For that reason, a Bereavement Program became one of the goals of this Palliative Care program.

The Palliative Care Clinical Nurse Specialist elicited the assistance of multidisciplinary colleagues including Medicine, Social Workers, Spiritual Care, Hospital Administration and Public Relations to form a Bereavement Team. Although the Palliative Care program is primarily focused on adults, participation from Pediatric representatives was also welcomed and encouraged. Four initial primary goals were identified:

a. Bereavement cards for Palliative and Oncology patients
b. Follow-up phone calls for the survivors of Palliative patients
c. A Celebration of Life service for survivors of Palliative and Oncology, as well as medical and hospital staff members involved in their care
d. A Bereavement Packet with resources on grief as well as practical information for survivors.

Practice Change:
Prior to development of the Bereavement Program, the only resource available was an informally-created information packet offering outdated information. There was no organized follow-up with survivors. Although efforts had been made to create a Bereavement Program in the past, the momentum of this effort was not sustained.
**Evaluation:**
The Bereavement Team initially consisted of the Palliative CNS, Oncology Social Worker, a hospital Chaplain and the Palliative Administrative Assistant. The program was initially limited to Palliative and Oncology patients because of concern about limited financial and staff resources. However, as word about the effort spread, other Social Workers asked to become involved, and both Hospital Administration and Public Relations became interested, allowing the program to expand from the initial Palliative and Oncology populations to hospital-wide. A donation from a benefactor allowed the Team to have a card designed and professionally printed. This donation also paid for the first two Celebrations of Life and a Grant Proposal has been developed and submitted to obtain additional funding.

**Results:**
Feedback obtained from phone calls made by the Palliative CNS was overwhelming positive, with many survivors mentioning the Bereavement Card and the comfort it brought them. The first Celebration of Life was only attended by two family members and ten staff members, but the second one had expanded to include approximately 30 participants and many survivors brought pictures, memorial programs and mementos from their loved ones and spoke of the comfort that the Celebration brought them. However, the Bereavement Packet effort was stalled because of the need for feedback and administrative approval from multiple channels and contents were only finalized a year after initiation of the effort. This failure in providing a finalized version of the Bereavement Packet resulted in rejection of a Grant Proposal to obtain additional funding, but the Bereavement Team has been asked to resubmit this grant once the Bereavement Packet was ready.

**Recommendations:**
1. Assess and determine appropriate team membership early in the process, possibly via flash e-mail or announcement. The Palliative team was initially slow to start, but picked up momentum drastically as word-of-mouth led to recruitment of eager participants.
2. Elicit early assistance from public relations and grant-writing resources, if available. If not, know the limitations of your funding. This can help drive the specific goals that the Bereavement Committee sets.
3. Ensure that all necessary committees and departments are “in the loop” before trying to initiate an intervention, even something as simple as a card. Administrative, cultural and religious concerns need to be addressed.
4. Determine early on how you will assess the success of your program. Implementing an evaluation method after interventions are initiated is often difficult.

**Lessons Learned:**
1. Multidisciplinary collaboration was integral to the development of the program and its successes.
2. The Bereavement resources that a program can provide are dependant on both manpower (the Bereavement Team participants did much of the work on their own time) and finance (the ability to pay for a professionally printed card and the refreshments and decorations for the Celebration of Life).
3. The development of both the Bereavement Card and Bereavement Packet required feedback and assistance from multiple sources to address religious and cultural sensitivities.
4. Beyond informal feedback, program evaluation was challenging: the literature pertaining to Bereavement Program evaluation is limited and the manpower demands of an independent, unbiased evaluation were beyond the capabilities of the team (though this is a future goal).

**Bibliography:**
1. End of Life Nursing Care Consortium-Critical Care Training Program; Administered by the City of Hope and American Association of Colleges of Nursing, Updated in 2008.