Bereavement in the Time of COVID-19: Learning from Experiences of those Bereaved as a Result of Deaths in an Acute Hospital Setting in 2020

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Abstract
The COVID-19 pandemic has resulted in many people experiencing bereavement in challenging circumstances. In April 2020 at a large London Trust, a “Bereavement Welfare Hub” was established to offer support and advice by telephone to relatives and carers of all adults who died as inpatients. Data from BWH call records regarding 809 adults who died at the Trust in March, April and May 2020 were collated. A random selection of 149 call records were examined using thematic analysis. Six themes which influenced the bereavement experiences and grief status of call recipients were identified. These included family and community support, care up to the point of death, communication, care after death and death rituals and customs. Several factors positively and negatively influenced the experiences of people bereaved during the first wave of COVID-19. From these findings, recommendations have been made which have the potential to improve the bereavement experience, particularly during the pandemic era.

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Keywords
bereavement, COVID-19, grief reactions, telephone bereavement support, communication, death

Introduction

The excessive mortality and public health protection measures associated with the COVID-19 pandemic resulted in many people experiencing bereavement in extraordinary circumstances. Deaths in hospital during this time have differed in many ways to “normal”, including the preceding clinical course of illness and the ability of relatives to visit. In addition, rituals and ceremonies associated with death were severely disrupted and lockdown measures limited the support available from social networks. These factors, in addition to other psychosocial challenges associated with living through a pandemic, are likely to negatively impact upon the experiences of the bereaved which may in turn increase the risk of complicated grief reactions and longer-term psychological issues.

Complicated or prolonged grief disorder is present if a person exhibits intrusive symptoms and failure to adapt a year after a bereavement (Horowitz et al., 2003). Factors that influence bereavement-related complications include lack of advanced preparation for loss, and fewer supportive social networks (Vanderwerker & Prigerson, 2004). Complicated grief is more likely after a traumatic death (Lobb et al., 2010) and is associated with increased morbidity (Prigerson et al., 1997). Factors associated with development of complicated grief are commonly experienced by those bereaved during the pandemic, suggesting considerable numbers of people are living with long-term psychological, physical and social sequelae of their pandemic-related bereavement experience.

Studies examining bereavement during the pandemic have found that prolonged and complex grief is common (Dennis et al., 2022; Torrens-Burton et al., 2022). Importantly, these reactions have been linked to particular experiences. Twenty-eight interviews with family members conducted on average 9 months after bereavement due to COVID-19 death in intensive care units emphasised the importance of communication and visitation (Dennis et al., 2022). The inability to visit the dying and restricted funeral and after death rituals has been associated with feelings of anger, guilt and lack of acceptance of death (Torrens-Burton et al., 2022). The importance of observing faith practices associated with death has been highlighted, with Muslim interviewees describing disenfranchised grief when death rituals and practices were disrupted by health protection measures (Gabay & Tarabeih, 2022). The important role in communication that clinicians take on when visiting is restricted has been highlighted in a study which found that clinicians communicated more frequently with both patients and relatives the closer the patient was to death and often used video technology for these interactions (Everitt et al., 2022). Lower levels of psychological distress have been found in people who were able to visit at the time of death and attend funerals (Chen, 2022).
While distress after bereavement cannot be avoided, a better understanding of the factors associated with both negative and positive bereavement experiences could guide service improvements to better meet the needs of the dying person and the bereaved. Approaches aimed at reducing the impact of the pandemic on factors such as visiting, communication, social support and rituals associated with death and dying have the potential to reduce the likelihood of a negative bereavement experience leading to prolonged or complicated grief. These same approaches are likely to be of value beyond the COVID-19 pandemic.

King’s College Hospital NHS Foundation Trust was one of the busiest Trusts in the UK during the first wave of the pandemic, with more than 500 beds occupied by confirmed COVID-19 patients in early April 2020 (NHS England, 2020). As the number of inpatient deaths rose it was recognised that increased support for the bereaved would be required and that this should be offered, regardless of whether the cause of death was COVID-19 related. In April 2020, a “Bereavement Welfare Hub” (BWH) was set up to offer telephone calls to the next of kin of all adult patients who died at the Trust.

While the aim of the BWH was to support those experiencing bereavement as a result of a hospital death, call handlers’ records were found to contain a rich source of data with the potential to inform service improvement and give valuable insight into the bereavement experience during the pandemic. This paper presents an analysis of call handlers’ records, describing the experiences of the bereaved with the aim of identifying ways in which bereavement experience could be improved. The service development of the BWH will be discussed elsewhere.

Methods

The BWH Calls. Next of kin of adults who died at the Trust from 11th March 2020 (the date of the first COVID-19 related death) were contacted by a member of the BWH team 8-12 weeks after the death. Thirty staff members from various health and social care backgrounds were trained by the palliative care team to make these telephone calls which offered emotional support, practical advice and referral for specialist bereavement counselling if indicated.

Data Collection. Demographics relating to each deceased patient for which a BWH call was made including age, sex, location of death (hospital site and ward type) and COVID-19 status were recorded.

Each call recipient was offered the opportunity to speak about their experience of bereavement, including hospital care, support and any other issues. Call handlers were guided to enquire about experiences, but the calls were designed to elicit the organic development of conversations about care, rather than ask structured questions. Notes on these conversations were made, but call recipient’s comments were not recorded verbatim. There was variability in the level of detail and objectivity in records from different callers.
Ethical approval was not required as this was part of a service evaluation.

**Quantitative Analysis.** The demographics of those deceased were described using descriptive statistics (SPSS Statistics software V.22).

**Qualitative Analysis.** This analysis used records from calls made regarding deaths occurring between March 11th and May 31st 2020. A random sample of 149 of the total 809 call records were selected.

Notes made about the experiences of the bereaved were analysed using thematic analysis (Braun & Clarke, 2006). Firstly, notes from sampled call records were reviewed by three authors (SL, LC and JW) to gain familiarity with the data. An inductive approach was used to explore the call records avoiding assumptions as to what the data might reveal. Coding of semantic content was applied to all the call handler’s notes in the sample.

The first 15 call records were reviewed and independently coded by three authors (SL, LC and JW) using NVIVO 12 Pro (QSR international). Codes generated during this exercise were reviewed by the wider author group (SH and DG), which confirmed satisfactory consistency in coding and resulted in a preliminary codebook to be used for subsequent analysis. Following this, the remaining 134 records were divided between three authors (SL, LC and JW) for coding. Any additions to the codebook identified during ongoing analysis were discussed and agreed between authors. Once all data were coded, authors met and reviewed the codes to begin generating themes.

Candidate themes were refined and codes within these themes checked for congruency and moved if more appropriate to other themes. Data that did not fit into any candidate theme was removed from the analysis. A thematic map was constructed to describe the relationships between the themes and the full dataset was reviewed again to confirm it was represented by the thematic map. Names for themes were selected and, where relevant, sub-themes identified.

To establish the relationship between grief status at the time of the call and bereavement experience, the content of each call was reviewed and categorised as either negative, positive or neutral. The case was categorised as negative grief status if there was evidence in the records of distress or difficulty coping, positive if there was evidence of appropriate adjustment or a positive approach and neutral grief status if there was sufficient information in the case records but could not be easily classified as positive or negative. Cases with insufficient information to make a judgement were not included in this analysis. The occurrence of factors identified in the thematic were then counted for each call and compared by grief status.

**Results**

There were 809 deceased adults listed on the BWH database at the time of analysis. The median age at death was 79 and 60% ($n = 481$) of patients had a positive COVID-19 polymerase chain reaction (PCR) result before death. Bereavement welfare calls were
completed in 82% (n = 663) of cases. In the remaining cases, it was not possible to reach the next of kin after three attempts. The median interval between death and the bereavement call was 48 days. There were no differences in details and demographics of the deceased in terms of age, sex, COVID-19 status and ward type between those who received a BWH call and those who did not (see Table 1).

There were a variety of different relationships between the call recipient and the deceased as illustrated in Table 2.

**Qualitative Findings**

A random selection of 149 records were explored using thematic analysis. There were no statistically significant differences in patient demographics between records selected for qualitative analysis compared to the full dataset (age $p = 0.33$, sex $p = 0.4$, site $p = 0.24$, COVID-19 status $p = 0.054$, ward type $p = 0.65$) (see Table 3).

On completion of coding, development and refinement of themes, it was agreed that data saturation had been met and no new codes or themes were identified.

Six themes were identified which were centred on the effect of the bereavement on the call recipient, described as the “bereavement experience”. Themes that influenced the bereavement experience included family and community support, care up to the

| Table 1. Patient Demographics. |
|--------------------------------|
| Whole sample (all that died) | Welfare call completed |
| $N = 809$ | $N = 663$ ($82\%$) |
| **Age** | | |
| Mean (SD) | 76 (13.9) | 77 (13.9) |
| Median | 79 | 79 |
| Minimum | 21 | 21 |
| Maximum | 101 | 101 |
| N | % | N | % |
| **Sex** | | |
| Male | 472 | 58.3 | 383 | 57.8 |
| Female | 337 | 41.7 | 280 | 42.2 |
| **COVID-19 status** | | |
| Positive | 481 | 59.5 | 397 | 59.9 |
| Negative | 183 | 22.6 | 159 | 24.0 |
| Not tested | 36 | 4.4 | 28 | 4.2 |
| Not recorded | 109 | 13.5 | 79 | 11.9 |
| **Ward type** | | |
| Critical care | 135 | 16.7 | 102 | 15.4 |
| Non-critical care | 674 | 83.3 | 561 | 84.6 |
point of death, communication, care after death and death rituals and customs. A thematic map is presented in Figure 1.

**Theme 1: The Bereavement Experience**

Many call respondents were experiencing a difficult bereavement journey. Adjectives used to describe emotions included feeling traumatised, distraught and shocked. Other
psychological effects included anxiety, low mood and guilt as well as prolonged feelings of loss.

“She broke down several times during our conversation and explained that she was very close to her Dad and misses him dreadfully”.

**Subtheme: The Additional Burden of COVID-19 Infection**

Some recipients had been unwell themselves with COVID-19 or described other family members being affected. Many had been symptomatic and voiced concerns about their ability to support family members and the need to delay funerals. The worry of another family member being unwell whilst going through the bereavement was an additional burden.

Two call recipients had other family members die from COVID-19, in addition to the deceased person who prompted the BWH call, with one describing three deaths in the family, all related to COVID-19.

**Theme 2: Support from Family and Community Positively Influenced the Bereavement Experience**

Call recipients described positive experiences of support from their community, most commonly from family. Specific examples involved children moving in with the surviving parent after the bereavement or making daily phone calls. One family
described how the children needed to provide continuous care for a parent who was frail and had unmet care needs following bereavement.

Other community support came from friends, faith groups (mosque, church and temple were all mentioned), GP and Cruse bereavement care. None of the respondents described using professional counselling services prior to the call.

**Subtheme: The Call from the BWH**

Call recipients valued the telephone call as a helpful medium for them to reflect on the life of the deceased. Calls were also described as helpful in the context of complaints, with the call recipients feeling supported through this process.

Where additional needs were identified, referrals were made by call handlers to relevant professionals for social support, practical assistance around funding funeral costs and locating missing property, bereavement counselling and to other health services. In some cases, call recipients had initially felt they didn’t need assistance, but the call had changed their perspective leading to the onward referrals.

“Family member and son are struggling and have now asked for a follow up from a specialist. They had previously been given contact details from GP but not taken this up.”

**Theme 3: There were Mixed Experiences of Care in Hospital up to the Point of Death**

**Subtheme 1: Satisfaction with Care**

Indicating satisfaction was a strong sub-theme and was expressed in many comments about hospital care. There were a variety of adjectives describing ward staff as compassionate, helpful and professional. Care was described as excellent, faultless, and going “above and beyond”.

“Can’t thank everyone enough - amazing care and updated regularly. Felt her father was in very good hands.”

Call recipients expressed gratitude towards nurses but also recognised the role of the wider multidisciplinary team (MDT). People described feeling comforted that their loved ones had received good care with staff doing all they could despite difficult circumstances.

“Overall care by the MDT was...exceptional and brilliant...all the staff were admirable given the circumstances that the staff were working under. An email of gratitude was sent to the hospital recently.”
Subtheme 2: Dissatisfaction with Care

Dissatisfaction was reported less frequently and in nearly all cases, specific reasons were given. Several call recipients found the deterioration of the deceased difficult to understand, questioning decisions around escalation of treatment and the cause of death.

“She could not understand this [the decision not to admit to intensive care] as the patient had ‘given up smoking 30 years ago.’”

Another call recipient described the ward team calling a few days before the patient died to arrange their discharge. Her father died a few days later and the prospect of the pending hospital discharge had caused her upset and anxiety in the days prior to his death.

There were also reports relating to the impact of staff workload on care.

“Needed to request a boost of syringe driver meds a few times during visiting - nurses were busy and the patient couldn’t communicate that she needed more meds.”

One call recipient explained how impotent he felt to influence how his wife’s needs were met in the hospital.

“Mr J. informed me he felt helpless because he could not help her when she complained...said his wife called him very distressed at times.”

Theme 4: Communication and Contact Influenced Satisfaction with Care and Mediated the Bereavement Experience

Subtheme 1: Communicating with the Ward

Many call recipients reported good communication with staff who kept them updated remotely. Telephone updates were valued, particularly when received on a regular basis and with adequate time for conversation. Positive remarks included “empathetic” and “explaining things well” during telephone updates.

“Very satisfied with MDT correspondence – this was all done by telephone.”

“Was calling twice a day, took the time to talk each time, didn’t feel like it was rushed.”

However, comments also highlighted gaps in communication about COVID-19 status, and ward moves. Difficulty contacting the ward by telephone and not receiving regular updates exacerbated feelings of anxiety.

“Felt ‘In the dark’ a couple of times and had to call the ward for updates.”
However, some call recipients anticipated and understood that communication with the hospital would be challenging due to the pressures associated with the pandemic.

“Struggled to get through to talk to someone for information about their father but thought this was to be expected given the situation.”

There were instances where communication about prognosis and expectations was inconsistent. Several respondents described being informed the patient was improving or doing well only a short time before they died.

“Son said the ward informed him she is improving but 2 hours later nurses called back and told family she is very ill.”

“Felt a mismatch between what was happening and the communication she received... received call from social worker about discharge and nursing home plans, later got a call to say mother was unresponsive.”

Other examples of suboptimal communication highlighted conversations relating to end-of-life care (EOLC) that felt blunt or like a tick-box exercise and disagreements about Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions. Expectations associated with the patient’s illness were infrequently documented, but where they were, it was to mention that the death was unexpected and that they had been shocked by the speed of the deterioration in the patient’s health.

**Subtheme 2: Communicating Remotely with the Patient**

Some call recipients had been able to speak directly to the patient before their death via personal mobile phones or facilitated via video calls or portable phones belonging to the ward. Where technical issues caused difficulty, verbal messages were relayed via staff members instead. Recipients were appreciative of the chance to stay in contact or to say goodbye and stated that this made an important difference to them.

“Family were very appreciative that the nurses arranged a video call with their dad on the hospital iPad at his bedside. Mr P. was able to say a few words and family were able to say their final goodbyes... the family found this most reassuring and comforting.”

**Subtheme 3: Visiting the Dying Patient**

Being able to visit the dying person was regarded as important with many comments relating to the ability and inability to visit. The reasons given for being unable to visit included ward restrictions, misunderstanding the visiting policy and physical constraints, such as health issues on the part of the call recipient or living too far away.
“Had to make decision not to come to hospital because of COVID-19 positive status.”

In cases where call recipients stated the ward had restricted visiting, there was some acceptance of this.

“She had no concerns except for visiting restriction. She understood that this was unprecedented times and the hospital had done everything they could to keep her informed remotely.”

Being unable to visit the dying person was uniformly difficult for call recipients and in many cases had negatively impacted on their grief.

“She is still struggling to come to terms with her father’s death, namely the fact they were not able to visit him.”

Where visits took place, experiences were mostly positive. The majority were grateful for the chance to see or speak to the person before they died. Staff were described as accommodating and that the visits were comforting.

“They thanked the staff for giving them this precious time to spend at their dad’s bedside in his last hours.”

**Subtheme 4: Presence at the Time of Death**

Those who were able to be present at the point of death described gratitude and feeling supported by hospital staff. Reasons noted for not being present included visiting restrictions or the patient deteriorating quickly or unexpectedly.

“Had been on the ward shortly before he died - went home but would have stayed if known death was going to be imminent.”

Call recipients who were not able to be present at the time of death found this difficult.

“Disappointed he could not be at his mother’s bedside when she needed her family most.”

**Theme 5: Efficiency and Empathy from Hospital Bereavement Services after Death Provided Much Needed Support**

Many call recipients expressed gratitude for the “helpful” and “professional” support provided by the hospital bereavement office following the death. Call recipients talked positively about being contacted in various ways including telephone and email. One
person spoke about receiving a letter of condolence from the specialist team that had cared for the deceased.

“Received letter after death from Myeloma team. Was appreciated.”

Personal gestures such as being sent a lock of hair from the deceased or a bereavement card and gift from the Trust were well received.

“N. was delighted to receive the card and seeds from the hospital, she thought that was a lovely gesture.”

Negative experiences with bereavement support related to administrative errors, time taken to get an appointment with the bereavement team and registering to use the Chapel of Rest.

A small proportion of call recipients reported that the property of the deceased person had not been returned. Call recipients expressed particular concern at the loss of sentimental items such as wedding rings.

Theme 6: The Impact of Restrictions on Rituals and Customs Associated with Death Affected Bereavement Experience

Religious rituals at the time of death were important to many call recipients. One wanted to know if the deceased had received the last rites from the Catholic priest, but this information was not available. Another stated that specific religious wishes were not taken into consideration. It was often difficult to view the body after death.

There were a range of negative experiences relating to funerals, including restricted numbers and “rushed” services. One call recipient stated it was “not the funeral we would have wanted”. Another described being unable to take the body overseas, while two reported that repatriation had been possible.

There were also cases in which overseas family were unable to attend services and where cultural and religious rites had not been observed.

“The one issue that distressed the family was the miscommunication between the undertakers and the hospital. Family were unable to carry out some of the Muslim rituals .... a ‘special Bath’ due to the hospital not providing the coronavirus status to the undertakers on time. This is still upsetting for family.”

Delays were common with some families waiting up to 6 weeks for the funeral service. Reasons for delay included increased demand for funerals and postponement due to family members being unwell or in hospital with COVID-19.

Positive comments were also made about funeral directors and crematorium staff, describing them as flexible and helpful. In multiple cases, digital solutions were used to allow for wider networks to attend.
“Jehovah’s Witness - lovely funeral via Zoom with lots of people joining all over the world.”

**Mapping of Themes to Grief Status**

There was sufficient information to categorise grief status in 136 of the 149 records. Of these, grief status was positive in 58, negative in 43 and neutral in 35 cases at the time of the call. Negative grief status was associated with inability to visit, poor funeral experience and omission of faith rituals. Whereas positive grief status was associated with reports of good care, good communication and strong support networks, including from faith groups. Reports of other family members with Covid-19 was uncommon and did not seem to affect grief status (see Figure 3).

**Discussion**

This thematic analysis of 149 BWH calls provides valuable insights into deaths during the early phase of the COVID-19 pandemic in a UK hospital. It gives a unique perspective on the particular challenges encountered by the bereaved during this time and highlights approaches which may be helpful to improve clinical services and support for the bereaved.

The mean age at death was 76 and just over half of call recipients were the children of the bereaved. However, there were a wide range of bereaved people including a small number of parents whose adult offspring had died. It is also important to note that most deaths occurred on general wards. Therefore, any recommendations to improve practice, including additional resources, should not be limited to critical care units.

The effects of the bereavement on the call recipient ranged from coping well to those with incapacitating grief. Concurrent illness and multiple bereavements were experienced by some. Family and community support contributed positively to grief status. Our data suggests that approaches to communication, visiting, administration, and death rituals and customs positively or negatively influenced the bereavement experience. Many of these features have been identified in other studies of pandemic related grief (Borghi et al., 2021; Katz et al., 2021; Kokou-Kpolou et al., 2020) and have been found to contribute to complicated grief more generally (Lobb et al., 2010).

Responses from the bereaved about hospital care were largely positive. Good feedback frequently related to personal and professional qualities of staff and the feeling that they did their best in difficult circumstances. Call recipients may have modified their expectations with respect to the pandemic, demonstrated in frequent expression of understanding that staff were overstretched. In the first few months of the pandemic, which these calls related to, satisfaction with NHS services was high, indicated by “clap for carers” and other initiatives (Wood & Skeggs, 2020). Subsequent waning in unwavering support for health services may uncover less tolerance for suboptimal communication or standards of care.
Timely and effective communication from the hospital in the time before death appears to strongly influence how relatives perceive the care of the deceased. Effective communication requires proactive and regular updates that are unhurried and display empathy and kindness. Inconsistency and the omission of important information (such as ward moves and knowledge of COVID-19 status) increases anxiety, leaving the bereaved with unanswered questions after the death. A significant issue was when relatives perceived that the patient was clinically stable, only for them to rapidly deteriorate and die, a situation which had anecdotally been common during the initial phase of the pandemic due to the clinical course of the illness (Filipovic et al., 2020). Previous studies have shown that caregivers who felt unprepared for death experienced more depression, anxiety and complicated grief reactions (Hebert et al., 2006). It is therefore imperative that staff communicate the risk of sudden deterioration and the “worst case scenario” to relatives in order to prepare them for this possibility. It is also necessary that staff provide accurate updates that reflect the patient’s condition, rather than attempting to provide false comfort. This is doubly important where relatives cannot visit and make their own appraisal of the patient’s condition.

The opportunity to communicate with the patient remotely and the chance to visit the dying person was universally appreciated. Where contact was not possible it was associated with feelings of distress, guilt and an inability to come to terms with the death. The powerful accounts given by call recipients attest to the need to prioritise facilitating this communication. Multiple options for remote communication should be available, in working order and ward staff should be familiar with their operation. Figure 2 illustrates the important findings regarding communication from this analysis.

Whilst routine visiting was restricted for infection control purposes, there was no policy at the Trust prohibiting visitation of dying patients at this time. Reasons for call recipients feeling unable to visit were variable, and there may have been differing interpretations of policy across the hospital. Therefore, it is important that compassionate visitation policies are disseminated to all relevant staff, published on external
websites and made available in different languages. Compassionate visitation policies should weigh up the tangible benefits of allowing visits against national infection control measures and restrictions (Downar & Kekewich, 2021).

Generally, call recipients were satisfied with bereavement services and they provided support with the administrative tasks required after the death. Call recipients mentioned meaningful additions to this service. During the pandemic, the Trust began a project which involved sending seeds and cards to the bereaved. Another example of a valued extra was a letter from a specialist team that had cared for the deceased.

Although misplacement of property was rarely reported, when it did occur it had an impact on the bereaved, particularly with respect to sentimental items. Ensuring that property remains with patients throughout their hospital stay and is returned to relatives should be a priority. Examples of good practice include electronic mechanisms for recording property on arrival and provision of designated bags to return property to the bereaved.

Rituals and customs around death were also identified as an important contributor to the bereavement experience. Whilst hospitals have no influence over funeral service provision, the availability of chaplaincy care and the communication of this with the bereaved is important.

Calls from the BWH have provided an important service. Firstly, by allowing the bereaved to talk about the deceased, which may have aided the grieving process, especially for people with few social connections, a situation that may have been exacerbated by lockdown restrictions. Secondly, by signposting support to the bereaved who may not have initially thought they needed help or who were not receptive to support when it was initially offered.

**Limitations**

The main limitation of this analysis is that it was undertaken on notes made by the call handlers which were not recorded verbatim. As this work formed part of a service development project, rather than research, there was no justification for recording and transcribing calls. Different call handlers may have recorded variable levels of detail and there were differences in focus of each conversation. Future developments would involve improving the consistency of records made by call handlers. As resources were not available to sample all calls, there may have been missed themes among non-sampled calls. A proportion of the bereaved were not contacted despite attempts and these people may have had different experiences to those described here. Ethnicity and other sociodemographic data were not collected.

There are limitations to the categorisation of grief status, as this was based on the quality of the information recorded and not on any formal assessment of grief. The data presented in Figure 3 should be considered with caution, in light of this caveat. Due to the timescale of the calls, it was not possible to establish whether call recipients were experiencing prolonged or complex grief disorder.
Figure 3. Illustration of important communication channels and characteristics.
Conclusion and Recommendations

The analysis of BWH calls identified several factors that contributed to a more positive or negative bereavement experience during the first wave of COVID-19 at a large UK hospital Trust. We recommend the following to improve the experience of those bereaved, particularly during pandemic surges:

1. Ensure regular communication between the hospital and the relative/carer that sensitively relays honest and unambiguous information on the patient’s condition and is delivered with empathy and without the use of medical jargon.
2. Wherever possible, arrange for contact between the patient and their relatives/carer, both in the time leading up to death and at the point of death. In-person visits should be the standard but where this is not possible, telephone or video contact should be facilitated.
3. Bereavement services should ensure the smooth running of administrative processes after death and support with returning property.
4. Rituals associated with death and dying are important and should be included in end-of-life care plans. Care should be taken to address religious and spiritual needs of the patient and their family before and after death and in the organisation of funeral services.
5. An accurate record should be kept of care provided at the end of life, including religious and spiritual care. This could be shared with relatives and carers after death, particularly if they were not able to be present.
6. The bereaved should be encouraged to seek support from their community, especially if family support is not available. This may be in the form of organised religion or other community groups. Support groups specifically for the bereaved may be another option.
7. Telephone-based services which proactively contact people bereaved as a result of a hospital death should be considered and data from such contact should be used to evaluate and drive improvement in hospital care and support for bereaved people.

Acknowledgements

We have acknowledging the following list of authors: Ann Spence, Christine Martin, Sophie Dalton, King’s College Hospital Charity, King’s College Hospital Social Workers, King’s College Hospital Specialist Palliative care team, Carole Price, Jane Tippett, Iona Joy, Will Bernal, Nicola Ranger, Nikki Larking, Ruth Dunlop, Steve Marshall, Elizabeth Lammie, Jennifer Morris, Suja Chandran, Rajes Naidoo, Lindsey Batty Smith, Katherine Potter, Marie Rousseau, Maggie Gunning, Michelle McHenry, Natasha Hulse, Emma Gee, Rosie Bamber, Orla Stewart, Nicola Oldcroft, Amanda Holland, Paul Mckie, Tendai (Ann) Kangai, Helena Munro, Alexis Nelson, Ellie Hickman, Victoria Osman, Sarah King.
Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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