NCPD 2.0 contact hours

Strategies for Virtual Bereavement Care

By Briana Marie Carr

Patients who die in isolation require unique care and hospitality from their nurses.

ABSTRACT: *The contagiousness of some illnesses (e.g., COVID-19) limits the ways in which families can interact with their dying loved ones who have been admitted to the hospital, especially in the intensive care unit. As a result, nurses have developed culturally relevant strategies for virtual bereavement care for patients and families predeath, perideath, and postdeath. Specific ways nurses can support, communicate, and facilitate meaningful rituals when patients die in isolation are provided in this article.*

KEY WORDS: *bereavement care, complicated grief, COVID-19, end of life, hospice and palliative care, nursing, pandemic, spiritual care, telemedicine*

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M.S.* is a 62-year-old female admitted to the medical intensive care unit for COVID pneumonia. She has been on the unit 3 weeks and remains intubated, sedated, and shows little improvement. The physicians discussed comfort care with M.S.'s family over the phone, but the family seems unready to consider that option. They verbalize understanding of M.S.'s condition, but state they are hopeful for a miracle. Hospital policy mandates that family of COVID patients are not permitted to visit due to risk of transmission, thus the family has been unable to see M.S. in person. The patient's daughter calls the unit twice per shift and is redirected so she can talk to her mother over speaker phone. Although M.S. is unable to respond or acknowledge that she can hear, her daughter shares Bible verses and prays for her mom, often weeping and pleading with God to save her mother's life. To provide support, the nurse remains present in M.S.'s room as her daughter speaks.

M.S. not only represents the many COVID-19 patients who died in isolation in the United States and worldwide, but the many others in years to come whose family won't be able to be physically present with their loved ones at the end of life. M.S. was a patient for whom I provided care. Like countless other nurses in this situation, I could not ignore the family members' pain. Although I tried to support this mother and daughter, I cried silently beneath my personal protective equipment (PPE). I wanted to comfort M.S.'s daughter but felt powerless to do so. How does a nurse convey comfort over a phone or computer to a family grieving death?

Jesus understood the healing power of grief when he wept for his friend, Lazarus, who had died of illness (John 11). Jesus mourned with Lazarus' sisters. John 11:33 (NIV) says Jesus was "deeply moved in spirit and troubled" by his friends' sorrow. Indeed, Jesus declared that those who mourn will be comforted (Matthew 5:4). In another example of Jesus' mercy and compassion, he healed the daughter of a Canaanite woman (Matthew 15), a non-Jew, demonstrating his love for all humanity. Christian nurses can learn from Jesus that comforting those who mourn is part of compassionate care.

How might nurses aid families who need to weep and mourn for their loved ones, especially when they cannot be physically present with the patient? Virtual bereavement care is a nursing therapeutic that rapidly developed in response to the COVID pandemic. This article reviews extant literature to identify strategies helpful during the predeath, perideath, and postdeath phases of bereavement, along with clinical tips from nurses on one COVID medical intensive care unit (ICU).

BEREAVEMENT, GRIEF, & MOURNING

Bereavement, grief, and mourning are not interchangeable terms. For this article, *bereavement* is defined as experiencing the loss of someone who is meaningful or influential in a person's life. Grief is the physical and psychological effects of dealing with bereavement. Characteristics of grief can include, but are not limited to, anger, disbelief, yearning, sadness, and depression. Grief is a permanent experience because people never stop feeling sad over a loss or stop missing the individual, but the intensity of grief generally lessens with time. *Mourning* is how a person copes with bereavement by coming to terms with the loss and a world in which the loved one is no longer present (Shear, 2012).

Grief and mourning are normal, healthy reactions to death; yet, everyone experiences grief differently. Although there are several theories of grief, most thanatologists agree that stages of grief are fluid and do not necessarily occur in a specific order or without relapse (Nakajima, 2018). Some bereaved persons experience *complicated grief* (CG), a maladaptive condition distinctive from depression where a person grieves for a prolonged

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period and is unable to process a loved one's death (Gesi et al., 2020).

There is little evidence regarding the process and outcomes of bereavement for families of COVID patients who died while isolated in a hospital. Researchers predict severe negative outcomes, such as CG, for these family members (Stroebe & Schut, 2021). Negative outcomes for the bereaved are thought to be related to the shock, trauma, and unexpectedness and isolation of COVID deaths.

A literature review of CG during the initial coronavirus pandemic by Gesi et al. (2020) explored CG after natural disasters and diseases requiring ICU treatment. They reported that CG occurs more commonly in females, individuals with less education, people who lack social support, and those who suffer from posttraumatic stress disorder (PTSD) symptoms. Fifty percent (50%) of family members of patients who died in an ICU and those not provided with bereavement support following a death were also at risk for CG. Factors such as poor communication between the family and the care team, inability of relatives to say goodbye to the patient, death occurring while the patient was intubated, and the perception by family of poor care all increased the likelihood of CG (Gesi et al., 2020). These findings may be extended to deaths experienced by families during the COVID-19 pandemic, especially those that occurred in the ICU and without family present.

VIRTUAL BEREAVEMENT CARE

Predeath

One of the first steps to support a potentially dying patient's family is to help them recognize the seriousness of the patient's condition. Indeed, preparing patients and families for death plays a major role in working through anticipatory grief, which reduces the likelihood of CG (Wallace et al., 2020). During the COVID-19 pandemic, patients admitted to an ICU were 5 times more likely to die in the hospital than patients with other diagnoses (Cates et al., 2020). Although it may be difficult for a family to accept, being honest from the beginning helps establish a trusting relationship.

If the patient has not completed an advance directive (AD), encourage patients who can to create an AD so that healthcare providers and families may respect the patient's wishes. Advance directives allow for a clear understanding of treatment expectations before a patient is actively dying (Carr et al., 2020). When initially assessing a patient, discuss the patient's goals of care and desires to be resuscitated, should the need arise. An existing template for ADs can be used to help the patient identify who their healthcare agent is, what their wishes are if they are unable to make decisions, goals for their death, and any spiritual or cultural requests. Hospital staff usually have access to AD forms through their institution. Free resources also are available to construct an AD (See Table 1: Free Resources for Advance Directives, online as supplemental digital content [SDC] at http://links.lww.com/NCF-JCN/A103).

However, if a patient's condition prevents the completion of an AD, there is no option for family members to complete an AD on the patient's behalf. Instead, the family may speak with the care team about what they believe their family member's goals of care would likely be. Thus, it is crucial to discuss an AD with all patients who are admitted if they are able to make decisions for their care.

Finally, nurses may utilize psychosocial assessment skills to understand the family's preparedness for death, as well as their support systems. In one study of the connection between grief preparedness and bereavement, families who were the least prepared for a loved one's death had the poorest outcomes with CG (Nielsen et al., 2016). Questions such as the following may be helpful (Pfefferbaum & North, 2020):

- It is standard practice here when a patient is seriously ill that we talk to the family about preferences for care in case their loved one passes away. Would it be okay if I asked you some questions about that now?
- What measures would your family member like to be taken if needed, such as cardiopulmonary resuscitation (CPR), being placed on a machine to help breathing, feeding tubes, etc.?
- What do you know about your family member's wishes with regard to how they want the end of their life to be? If your loved one were to die here, what are your wishes for how their death might be? (If the family member does not identify any from the previous prompt, ask: What cultural, spiritual, or religious practices would be important for us to know?)
- Would your loved one's death cause an immediate hardship (such as financial trouble) for you or your family?
- Who or what resources can you rely on for support during this difficult time? How would you like us to support you?

Depending on the family's answers to these questions, either provide a referral to social work or chaplaincy, or discuss culturally specific recommendations for preparing the family for death (LeRoy et al., 2020). It is important to support dying patients and their families with care that allows them to find solace in their own religion and culture. For example, if the patient is Catholic, ask if the family wants a priest to administer the Sacrament of the Sick to the patient through the door, even if the patient is unable to respond. If the patient is Jewish, acknowledge the family's desire to always have someone with the patient after death has taken place and offer to remain near the patient's room until the body is moved to the morgue (Taylor, 2019a).

Navigating Difficult Conversations

One challenge nurses face while caring for patients who may die in isolation is finding comforting words.

Table 2. Tips for Virtual Bereavement Care with Families

Prepare	• Be familiar with the patient's history; explore the healthcare record • Use the patient's name • Ask the family what they know about the patient's condition before discussing treatment or prognosis
Build rapport	• Ensure ample time so questions may be answered without being rushed • Provide a private area for the virtual meeting that is free from distractions and facilitates undivided attention • Use body language to show full attention to the family
Practice effective communication	• Avoid confusing terminology • Speak slowly and clearly • Allow periods of silence to facilitate comprehension and help acceptance • Direct conversation at the family's pace
Express empathy	• Address family concerns and emotions • Allow the family to express feelings: practice active listening, express empathy, explore feelings
Validate feelings	• Allow the family to reiterate information; correct misunderstandings • Discuss how the patient's condition will affect the family • Be aware of your own feelings and other staff's reactions in the meeting
Offer hope	• End the interaction with hope; tell family specific interventions that may be done to relieve pain and discomfort • Discuss ways in which the family may offer comfort from afar

Given that family members cannot be physically present to touch or speak to their loved one, nurses must navigate conversations with family members by phone or video conferencing. Preparing staff with examples of potential conversations with families provides words nurses can use to offer comfort. Table 2 illustrates specific talking points and actions a nurse can utilize when speaking virtually to a dying patient's family.

Specific phrases and word choices have been compiled by palliative care teams to support providers when discussing difficult information with family members (Berkey et al., 2018; Kelemen et al., 2020). For example, the family may ask about their loved one's suffering and dying alone. Acknowledge their fears and reassure the family that there are interventions for managing pain and symptoms of death, and that you will work to be fully present with their family member. Suggest the family think of ways their loved one could feel their presence, such as a favorite object from home or family photos (Kelemen et al., 2020).

Another difficult conversation is when a family member is distraught that a child is not able to say goodbye to the dying patient. Begin by acknowledging the family's pain and then discuss explaining to the child why they cannot come to the hospital. Inquire about the child's relationship with the dying person to brainstorm ideas to help the child say goodbye in their own way. For example, suggest the child draw a picture to hang in the patient's room or sing (or record) the loved one's favorite song over the phone for the patient to hear (Kelemen et al., 2020). Make the response person-centered and empathic with the family's emotions instead of simply providing facts about their loved one's condition.

Video Conference Visits

When family cannot be physically present with a patient, discuss options for video conferencing to help decrease both patient and family anxiety (Kamali et al., 2020). In a qualitative study of virtual visits for bereaved family members who were isolated from their family member dying with COVID in an ICU, family members ($N = 57$) reported that virtual visits provided happiness, gratitude, relief, and closure (Sasangohar et al., 2021). In another study, family members asserted that virtual communication was inferior to in-person meetings but also reported that video visits were effective for receiving updates and letting the family see their relative (Kennedy et al., 2021). Kennedy et al. (2021) observed that both the ICU staff and the families recommended the following: Assign one family representative for the staff to update on camera; frequently check for the family's understanding of the situation; and ensure the patient is visible on camera during the visit so that his or her condition can be observed.

Scheduled video visits provide family members with valuable information regarding the patient's condition, helping them make more informed decisions regarding care. Although it is difficult to see a loved one on a ventilator with tube feedings running and towers of intravenous medications, it is a sharp contrast to hearing an update about the patient's condition over the phone. In a study about virtual ICU visits, families reported that seeing the patient via video impacted their discussions of treatment with the healthcare team (Mendiola et al., 2021). For example, a family who sees the severity of their loved one's illness may decide to place the patient on comfort care instead of continuing full treatment.

Several difficulties arise, however, when considering a virtual visit with an ICU patient. For example, if the

patient is intubated and sedated and not able to respond, the family may feel frustrated. Before initiating the video visit, explain to the family what they might see (Wang et al., 2020). Describe the different lines, tubes, and machines and explain why the patient is unable to speak. In addition, tell the family that just because the patient is not able to respond does not necessarily mean that he or she cannot hear. Encourage the family to speak to the patient as if they can understand what is being said.

Another struggle associated with video conferencing is limited numbers of electronic devices. To address this issue, the unit can establish a scheduling protocol. The unit secretary can schedule daily video conferences for each patient with their family and notify nurses of the scheduled appointment so nurses can anticipate facilitating the meeting and plan care accordingly. This can help ensure that patients and their families have access to a video conference despite limited resources and complex family and clinician schedules.

Family members may want to include the nurse in the virtual meeting, but the nurse may be unable to participate for an extended period. To mitigate this issue, the family can be asked ahead of time if they would like the nurse present. If needed, establish boundaries for the meeting, such as telling the family you are only available for the first 5 minutes of the visit or when you return to the room to end the video visit. Another option could be to include informed ancillary staff in virtual visits.

Video Conferencing with Families

In addition to providing a platform for family visitation, video conferencing is a tool for the care team to update the family and discuss the plan of care. For patients who are dying in isolation, the nurse can use several accommodations to improve virtual communication with families (Kelemen et al., 2020):

- Find a quiet environment free from distraction (e.g., silence pagers and phones).
- Use an unhurried, gentle voice to create an environment of calm.
- Set rules for meeting (e.g., ask for full attention [mute phones] and promise care provider's attention; suggest a time limit).
- Ask what the family would like to talk about or what information may be most helpful.
- Ascertain family understanding of the situation; inquire as to their needs and goals for the meeting.
- Identify the loved one by name.
- When explaining the patient's condition, if appropriate, consider using the word dying to describe the magnitude of the situation and prepare the family. Although naming the process of dying may seem offensive, it helps prevent miscommunication.
- Avoid using terms unfamiliar to the family that may make the conversation difficult to understand.
- Give time for silence to allow the family to process.
- Ask the family what the team needs to know about their loved one to be helpful in providing care.
- Ask about patient and family values to inform goals of treatment in proceeding with care.
- Explain clinical recommendations and allow the family to share their hopes for the patient's death.
- Provide an opportunity for questions.
- Clearly reiterate the treatment plan and expected outcomes to help ensure understanding.
- Schedule the next video conference to ensure the family feels involved in their loved one's care and are receiving updates.
- Reassure the family that everything will be done to make their loved one as comfortable as possible.
- Offer hope by discussing specific comfort care measures that may be taken to alleviate pain and suffering.

Houston Methodist Hospital integrated a virtual ICU into each COVID patient's room (Cherniwchan, 2022) using built-in video cameras, supportive care delivery, and specialist

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consultations that could be completed without the bedside nurse. The virtual ICU reduced staff burnout, lowered patient mortality rates, spared valuable PPE, and offered more caring interactions for patients. Virtual ICUs may provide more individualized care for patients, support family involvement in care, and allow both staff and family members to have more intimate interactions with a patient.

Virtual bereavement care is a nursing therapeutic that rapidly developed in response to the COVID pandemic.

Perideath

Families can be encouraged to provide a token for the patient to have such as a blanket, shirt, or family heirloom (Wang et al., 2020). Families can later choose to place this item with the patient upon burial or cremation, or keep the object. Additionally, encourage the family to record a voice or visual message to be played for the patient to provide family presence. Suggest messages of love, gratitude, forgiveness, and farewell to help comfort the patient, as well as to provide closure for the family (Exline et al., 2012).

It is important to discuss cultural and religious practices related to death with a patient or their family to help guide culturally sensitive care. Recognize the family's heritage and encourage them to incorporate religious and cultural practices into their messages to their loved ones, as heritage may help a family make meaning of the situation (Walsh, 2020). For example, if the patient is Jewish, the family may record a reading of Psalm 23 and of the Shema prayer that is said before death. If the patient is Muslim, family members can record a reading from the Koran or recite prayers. If the patient is Christian, friends and relatives may want to record the Lord's Prayer (Matthew 6:9-13) or other Scripture to be played as the patient is dying. Buddhists may want to chant their holy Scripture prior to and at the time of death (Taylor, 2019a). Nurses can obtain chants, readings from holy Scriptures, and other religious audio-recordings from the Internet and hospital chaplains can provide recommendations.

If desired, family can be present via video conferencing while the patient is actively dying. This decision must be made by individual family members, as it may not be appropriate for all. The benefit is that the patient may hear family members' voices as if present in-person. Additionally, the family may have peace knowing that their loved one was not alone when they died. However, observing a loved one's death may be traumatic. In fact, families who witnessed an ICU death virtually were at an increased risk of PTSD and CG (Selman et al., 2020). Thus, in some cases, the family may determine that comprehensive, yet sensitive updates may be more fitting than observing their loved one's death. An alternative to viewing a patient's death via video may be granting a family member a humanitarian visit to the unit to observe the patient from behind the closed room door through a window.

During active dying, encourage the family to opt for comfort measures for the patient. These may include a morphine drip with optional boluses of benzodiazepines to reduce pain, discomfort, and the work of breathing. Such interventions can reduce discomfort not only for the patient, but also for the family members who may be disturbed by watching the physical process of dying. To comfort families present outside the room, have tissues and drinks available and suggest the family play their loved one's favorite song or read Scripture or poetry aloud. Although the patient may not be able to hear their family through closed doors, reciting their loved one's favorite verses can provide the family comfort and peace.

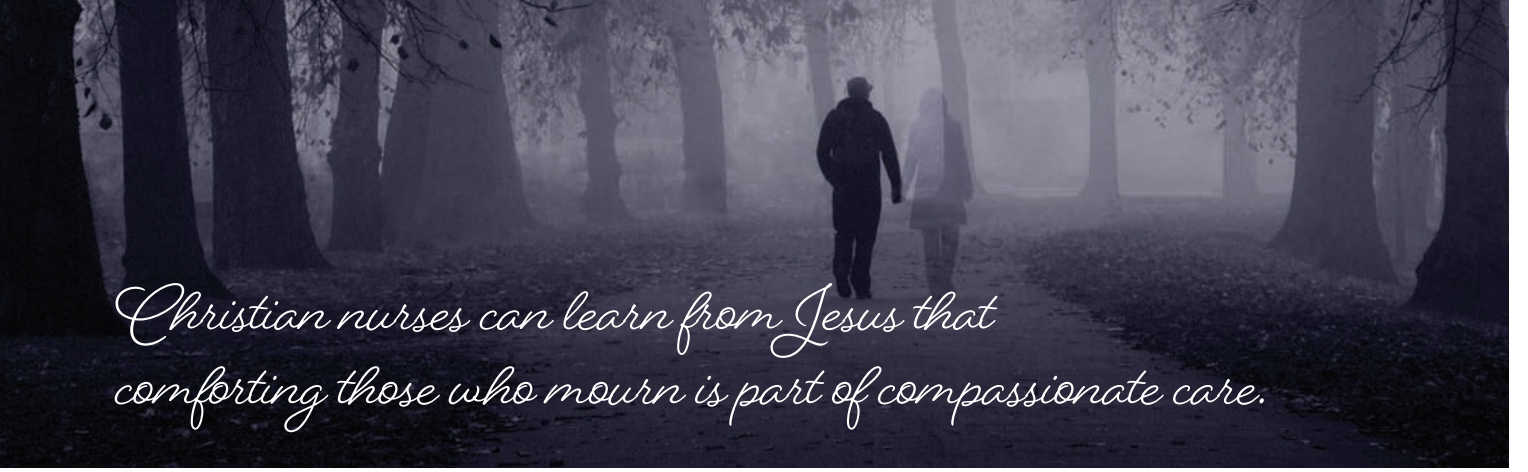
Postdeath

Soon after the patient's death, offer to take a dignified photo to offer a sense of closure to the family and to confirm that death has occurred (Wang et al., 2020). Consider what a dignified photo may require:

- Removing all unnecessary lines and tubes per protocol.
- Closing the patient's eyes and mouth.
- Including the family token in the picture if one was provided.
- Capturing a close-up of the patient's hands, perhaps with a wedding ring displayed.

In addition, offer to print the electrocardiogram (EKG) strip of the patient's last heartbeats to memorialize the last moments of life. Provide the family with the strip, along with a sympathy card. Some ICUs stock ink for handprints to be taken following a patient's death (Morris et al., 2020). Offer to make a handprint of the patient and/or cut a small lock of hair as a keepsake.

Nurses can encourage family members to honor their loved one after death. Assess the family's religious and cultural practices and provide a chaplain referral or ask if their community clergy may be contacted on their behalf. Offer suggestions for carrying out death rituals, realizing that large gatherings may not be permitted during a pandemic. Provide safe suggestions for memorializing the dead, such as through virtual celebrations of life, hanging pictures outside of a person's house, or cooking the loved one's favorite meal (Burrell & Selman, 2022). Suggest family members write stories about their loved ones to share with future generations, create a scrapbook of



memories, design a video documentary of their loved one's life, or share pictures and memories on social media and encourage others to remember their loved one (LeRoy et al., 2020).

Unfortunately, some postmortem religious practices interfere with protocols of isolation and social distancing. For example, Buddhists leave a body untouched for 3 days (Taylor, 2019a). Jews may want someone to sit with the body until it is interred. However, isolation protocols and high patient census prevent respecting these practices. Nurses may need to explain that some practices cannot be observed and can request a chaplain to help negotiate how alternative meaningful practices can be followed.

Finally, offer virtual bereavement groups to help families cope with their loss and connect with others. Additionally, discuss seeking the support of a mental health professional who is experienced in working with grieving individuals, especially for families who are at a greater risk of CG.

SPIRITUAL CARE

The COVID-19 pandemic presented unique challenges for nurses striving to support the physical, mental, and spiritual health of patients and families. David, the biblical psalm writer, reassures that God is "close to the brokenhearted and saves those who are crushed in spirit" (Psalm 34:18, NIV). Jesus said, "Blessed are those who mourn, for they will be comforted" (Matthew 5:4, NIV). The Bible offers excellent reminders of God's love and care in times of need (e.g., Isaiah 41:10; Philippians 4:19; Romans 8:28-38).

God repeatedly calls upon people to care for the sick. In Galatians 6:2, the apostle Paul reminded us to bear the burdens of others. In Romans 12:13, Paul encouraged people to practice hospitality and share with others who are in need. Patients who die in isolation require unique care and hospitality from their nurses.

Virtual bereavement care can include overtly spiritual and religious care. To determine appropriateness and ensure ethical care, it is important to assess spiritual needs and preferences (Winslow & Wehtje-Winslow, 2007). For example, a nurse can screen for spiritual distress with a question like, "Are you at peace?" or "Is there an inner pain that is not physical?" (Taylor, 2019b). To assess for preferences, ask, "Are there any spiritual or religious practices that would be comforting for you now?" Follow up by implementing practices if possible. For example, a nurse may play an audio version of the Bible for a patient or YouTube renditions of inspirational songs.

Another way to give spiritual care for isolated patients and their families is to offer prayer (Taylor, 2020). Ask patients if prayer would be helpful and when appropriate, encourage patients in isolation to pray, or pray with patients to support them with God's comfort and love (James 5:13-14). Table 3, available online as SDC at http://links.lww.com/NCF-JCN/A103, offers Bible passages related to grief that nurses can use for themselves or, when appropriate, with patients and families.

CONCLUSION

Nurses who navigate patient deaths in isolation must adapt to the changing environment and provide virtual bereavement care. They must learn to incorporate virtual family updates into their schedules and work with the interdisciplinary team to ensure communication with families. As virtual technology expands, nursing education can include virtual bereavement care in the curriculum to equip new nurses to care effectively. Similarly, nurse residency programs can offer simulation training to practice providing virtual bereavement care.

To support virtual bereavement care, leadership teams may need to budget for communication devices, such as electronic tablets. In addition, management may need to consider increasing the budget for items used in end-of-life care, such as ink for hand printing or portable electronic devices to play family recordings or music.

More evidence is needed to guide effective virtual bereavement care. Research is needed to not only determine outcomes of virtual bereavement care, but also to understand how gender, culture, religion, and age might impact care. More documentation on the plethora of clinical strategies nurses use needs to be shared to provide lessons and tools for future nurses. Finally, researchers could survey the effects of virtual bereavement care on nursing satisfaction, retention, and mental health.

Nurses have cared for hundreds of thousands of COVID patients and developed and utilized virtual bereavement care for their families. Utilizing technology and supportive communication with patients' families has become a mandatory skill, especially for ICU nurses. Nurses will continue to care for patients dying in isolation, thus making virtual bereavement care an important part of practice.

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