

Research Paper

The Needs and Problems of Bereaved Families in Hospitals: Perspectives of the Bereaved Families and Medical Staff



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ABSTRACT

Background and Objective: The present study aims to explore the needs and problems of the bereaved families in hospitals from the perspectives of bereaved families and medical staff.

Materials & Methods: This is a descriptive cross-sectional study on 257 medical staff working in teaching/medical hospitals in Sari, north of Iran, affiliated with Mazandaran University of Medical Sciences, who were in direct contact with bereaved companions from the admission stage to discharge and 102 bereaved family members who had lost a loved one in these hospitals in the past year. The sampling method was census. The data collection tools were a demographic checklist and two researcher-made questionnaires to survey the needs and problems from the perspective of medical staff and bereaved relatives. The collected data were analyzed in SPSS software, version 22 using descriptive and analytical tests (Mann-Whitney U, Kruskal-Wallis, and Spearman's correlation).

Results: More than 90% of the medical staff stated that there was a need for a separate unit in the hospital for the decedent affairs and a bereavement room for bereaved families. More than 70% of the medical staff considered the presence of first-degree relatives and a chaplain in the final hours of the patient's life, and the greatest dissatisfaction of bereaved families was the lack of a guide for the discharge of the deceased person, and the difficulty in finding an ambulance for discharge. More than 90% of bereaved families agreed that a separate unit was needed in the hospital to deal with the affairs of the deceased person. About 94% of bereaved families mentioned the need for transportation services in the discharge unit. More than 90% of bereaved families needed to be in the ward during the patient's final moments. More than 90% of bereaved families stated that the medical staff treated the bereaved families and the deceased person appropriately.

Conclusion: Both bereaved families and medical staff identified welfare-related needs and problems as the most important ones. It is recommended that hospitals create a bereavement room and a separate gathering hall for bereaved families, and pay special attention to communication skills, especially in the field of bereavement care, in specialized training programs for medical staff.

Keywords: Needs assessment, Grief, Death, Medical staff, Hospital, Family

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Introduction

Grief is an emotional reaction to the loss of a beloved one [1]. Every person may experience grief and sorrow at some point in their life [2]. At older ages, grief and bereavement are more common [3] and can be a very stressful experience for the families [1]. As people become older, they have to accept and adapt to the death of a loved one [4]. Depending on the nature of death, the reactions of bereaved people vary. For example, in the case of an imminent death, bereaved people may express uncertainty, fear, and sorrow, which can have adverse effects on their health [2]. Grief among the caregivers of cancer patients can lead to more intense sadness and more unfavorable consequences [5]. The majority of people often adjust to the loss of a loved one and continue their lives within a few months; however, some may experience prolonged and more intense grief [4], which has psychophysical and economic risks for their relatives [6] and can affect the social and emotional well-being of the bereaved person.

Most people die in hospitals, and the in-hospital care providers often encounter bereaved people [7]. The death of a patient in a hospital has a negative psychological impact on their families [8]. Support of bereaved family members is a part of care, which includes providing information and emotional support [8]. Research is required to identify and discover effective strategies in this field to help reduce the post-death grief of the bereaved people [5]. The current screening and support of the bereaved people are not enough. It is obviously necessary for the intensive care units to provide screening services and bereavement follow-up for family members [4].

Various quantitative and qualitative studies have been conducted on grief and the problems of the bereaved people [4, 9-13]. However, no research has investigated the needs and problems of the bereaved people from the perspectives of the medical staff. Therefore, considering the importance of support for the bereaved people and their satisfaction, the present study aims to explore the needs and problems of the bereaved people perceived by hospital staff in Iran. By identifying the needs and problems of bereaved families, we can develop effective strategies to meet their needs and address their concerns within hospitals.

Materials and Methods

This is a descriptive cross-sectional study conducted from June 3, 2016, to October 7, 2017. The study population consists of all medical staff working in teaching/medical hospitals in Sari, Iran ([Imam Khomeini](#), [Bu-Ali Sina](#), [Fatemeh Zahra](#), and [Zare](#)) affiliated with [Mazandaran University of Medical Sciences](#), who are in direct contact with bereaved families from hospital admission to discharge, as well as bereaved families who had lost a loved one in these centers in the past year.

The inclusion criteria for medical staff were a direct interaction with bereaved families and willingness to participate in the study. The inclusion criteria for bereaved families were being relatives of the deceased, who were seeking to discharge the body of the deceased person within the mentioned period. For both groups, the exclusion criterion was the lack of answers to 20% of the questions on the questionnaire. A census sampling method was used for selecting medical staff bereaved families. After approval from the Ethics Committee of [Mazandaran University of Medical Sciences](#) and obtaining permission from the hospitals, the researcher visited the hospitals for sampling.

The data collection tools included a demographic checklist and two researcher-made questionnaires to examine the needs and problems of the bereaved people from the perspectives of medical staff and bereaved families. The demographic checklist surveyed information about the deceased person (gender, marital status, cause of death), the families of the deceased person (gender, marital status, relationship with the deceased), and the medical staff (age, gender, marital status, educational level, type of employment, and serving place). The questionnaire that surveys the needs and problems of the bereaved people from the perspective of medical staff has 29 items, and the questionnaire that surveys the perspectives of bereaved families has 26 items, both based on a Likert scale from 1 (absolutely agree) to 4 (absolutely disagree). Both questionnaires measure needs and problems in three areas of welfare, support, and communication. In the questionnaire surveying the perspectives of medical staff, items 1, 2, 16 are the communication domain, items 3,7,8,9, 17,18, 19, 26, 27, and 29 for the support domain, and items 4,5,6,10,11-15,20,21-25, and 28 for the welfare domain. In the questionnaire surveying the bereaved families' perspectives, items 2-8 and 15 are for the communication domain, items 1,9, 20,21,23,25, and 26 for the support domain, and items 10-19,22, and 24 for the welfare domain. A lower score indicates greater needs and problems. Finally, both groups also answered two open-ended questions to measure their satisfaction.

The validity of the questionnaires was assessed qualitatively and quantitatively based on the opinions of 11 faculty members of the Nasibeh School of Nursing and Midwifery, [Mazandaran University of Medical Sciences](#), and corrections were applied based on their comments. A content validity index (CVI) of 0.88 and content validity ratio (CVR) of 0.72 was reported the questionnaire surveying the perspectives of medical staff. For the questionnaire surveying the perspectives of bereaved families, CVI=0.93 and CVR=0.74. The Cronbach's α for the two questionnaires was found to be 0.86 and 0.90, respectively.

Before distributing the questionnaire, the study objectives and methods were explained to the participants, and their informed consent was obtained. Depending on the conditions of the bereaved families, the questionnaires were completed sequentially or intermittently. For the medical staff, the questionnaires were delivered to the head nurse or unit manager. Then, the researcher visited the units to collect the completed questionnaires. The collected data were analyzed in SPSS software, version 22 using the Kolmogorov-Smirnov test, descriptive statistics (frequency, Percentage, Mean $\pm$ SD), Mann-Whitney U test, Kruskal-Wallis test, and Spearman's correlation test.

Results

Participants included 257 medical staff and 102 bereaved families. The majority of the deceased people were male and married (52.9%), and the most common cause of their death was disease (76.5%). Most of the bereaved family members were male (58.8%), married (74.5%), and the deceased individuals' children (82.4%). The medical staff were in the age range of 23-55 years (Mean $\pm$ SD, 33.94 $\pm$ 7.71 years); 80.9% (n=208) were female, 75.1% (n=198) were married, 84.8% had a bachelor's degree (n=218), and 36.2% (n=93) had permanent employment ([Table 1](#)).

The needs and problems from the perspective of medical staff

About 73% of medical staff perceived the presence of the patient's first-degree relatives at the end of life stage as necessary, while 80% stated that the presence of a chaplain at the end of life can provide emotional comfort to the relatives. More than 90% stated that the existence of a separate unit in the hospital for decedent affairs can be helpful for both the families and the medical staff. More than 90% believed that informing the families about the patient's death is a difficult task for them and that they do it out of compulsion. Also, 94% perceived

it necessary to have a liaison officer in the hospital to inform the families about the patient's death. More than 97% stated that the presence of all bereaved relatives in the ward can bother other patients. Furthermore, 80% stated that the presence of only one first-degree relative when transferring the deceased person from the ward to the mortuary is sufficient, and when there is no companion, the medical staff can better perform the tasks related to the deceased person. Moreover, 98% stated that seeing the bereaved people upon entering the hospital makes them uncomfortable, and 92% recommended the presence of a gathering hall in the hospital to avoid seeing heartbreaking scenes when starting to work. Also, most medical staff opposed the idea that referring the deceased to the morgue could cause severe dissatisfaction among grieving relatives ([Table 2](#)).

Based on two open-ended questions, from the perspective of medical staff, the obvious needs and problems of the bereaved families included the bereaved families' lack of awareness of the services provided to the patient, lack of timely informing the families about of the patient's dying conditions, absence of a social worker after the patient's death, observation of the resuscitation stages and the patient's death by the families, delay in visiting doctors to write a summary of the case and issue a death certificate (delay in issuing a burial permit), along with the grief of losing a loved one and the heavy medical costs.

The mean score of the questionnaire surveying the perspective of the medical staff was 62.24 $\pm$ 7.4, ranging 42-79. The highest agreement rate was related to the communication domain, followed by the welfare and support domains, and the highest disagreement rate was related to the support domain, followed by communication and welfare domains ([Table 3](#)). In examining the difference in the mean scores of this questionnaire based on the demographic characteristics of medical staff, the results of the Mann-Whitney U test showed a statistically significant difference between males and females ($P=0.009$). However, based on the Kruskal-Wallis test results, no statistically significant difference was observed based on marital status ($P=0.848$), education level ($P=0.294$), or type of employment $P=0.011$ ([Table 1](#)). Also, based on the Spearman correlation test, there was a statistically significant relationship between the factors of age ($r=-0.308$, $P<0.001$) and work experience ($r=-0.332$, $P<0.001$) and the questionnaire score.

The needs and problems from the perspective of bereaved families

Table 1. Comparison of average questionnaire scores based on demographic characteristics of the deceased people, bereaved families, and medical staff

Characteristics			No. (%)	Test Statistic	P
Diseased person	Gender	Female	46(45.1)	-	-
		Male	54(52.9)		
		No answer	2(2)		
	Marital status	Married	68(7.66)	-	-
		Single	24(23.5)		
		No answer	10(9.8)		
	Cause of death	Natural	20(19.6)	-	-
		Disease	78(76.5)		
		Sudden death	1(1)		
Bereaved families	Gender	Female	36(35.3)	1.53 ^a	0.126
		Male	60(58.8)		
		No answer	6(5.9)		
	Marital status	Married	76(74.5)	1.833 ^b	0.176
		Single	14(13.7)		
		No answer	12(11.8)		
	Relationship with the deceased person	Parents	13(12.7)	0.219 ^b	0.640
		Children	84(82.4)		
		No answer	5(4.9)		
Medical staff	Gender	Female	208(80.9)	- 2.608 ^a	0.009
		Male	48(18.7)		
		No answer	1(0.4)		
	Marital status	Married	193(75.1)	0.037 ^b	0.848
		Single	60(23.3)		
		Divorced	1(0.4)		
	Educational level	No answer	3(1.2)	2.447 ^b	0.294
		Associate's degree or lower	13(5.1)		
		Bachelor's degree	218(84.4)		
	Employment type	Master's degree	18(7)	7.461 ^b	0.113
		No answer	8(3.1)		
		Permanent	93(36.2)		
		Contractual	16(6.2)		
		Under -a-contract	82(31.9)		
		Under project contract	43(16.8)		
		Under corporate contract	16(6.2)		
		No answer	7(2.7)		

^aMann-Whitney U test, ^bKruskal-Wallis test.

Table 2. The items for the questionnaire surveying medical staff's perspective regarding bereaved relatives' needs and problems

No.	Items	No. (%)		
		Agree	Disagree	No Answer
1	Informing death news to families is very difficult for us and we do it out of compulsion	240(93.4)	14(5.4)	3(1.2)
2	An liaison officer is required in the hospital to inform the families about the patient's death	242(94.2)	14(5.4)	1(0.4)
3	Coordination is required between hospital services for transferring the body to the morgue or the relevant departments	228(88.7)	22(8.6)	7(2.7)
4	Seeing the bereavement scenes when entering hospital creates unpleasant heartbreaking feelings in us	252(98.1)	2(0.8)	3(1.2)
5	A gathering hall for the bereaved relatives can avoid seeing bereavement scenes when starting to work	237(92.2)	16(6.2)	4(1.6)
6	The presence of all bereaved relatives in the ward bother other patients	251(97.7)	2(0.8)	4(1.6)
7	The bereaved relatives are usually reluctant to transfer the body of deceased person from the ward to the morgue	174(67.7)	74(28.8)	9(3.5)
8	All first-degree relatives should be present when transferring the body of deceased person to the morgue	73(28.4)	178(69.3)	6(2.3)
9	The presence of only one first-degree relative is sufficient when transferring the body of deceased person to the morgue	206(80.2)	47(18.3)	4(1.6)
10	The presence of first-degree relatives is not necessary in the ward during the end-of-life stage.	62(24.1)	187(72.8)	8(3.1)
11	The presence of first-degree relatives when wrapping the body is peaceful for the staff.	51(19.8)	198(77)	8(3.1)
12	Performing the deceased person's tasks is easier for us when the relatives of deceased person are not present	203(79)	45(17.5)	9(3.5)
13	The presence of a chaplain can bring comfort to patient during end-of-life stage.	206(80.2)	45(17.5)	6(2.3)
14	A separate unit in hospital for managing the deceased body's affairs is helpful for the medical staff.	237(92.2)	17(6.6)	3(1.2)
15	A separate unit in hospital for managing the deceased body's affairs is helpful for the bereaved families.	235(91.4)	16(6.2)	6(2.3)
16	Medical staff's behavior with the relatives can lead to a high dissatisfaction rate	49(19.1)	206(80.2)	2(0.8)
17	Transferring the body of deceased person to the Forensic Medicine Organization can cause a high dissatisfaction rate	91(35.4)	159(61.9)	7(2.7)
18	The bereaved relatives' inability to visit the deceased person in the ward can cause a high dissatisfaction rate	134(52.1)	119(46.3)	4(1.6)
19	The bereaved relatives' inability to be engaged in wrapping the body of deceased person can cause a high dissatisfaction rate	74(28.8)	174(67.7)	9(3.5)
20	The bereaved relatives' wasted time in the ward at the time of discharge can cause a high dissatisfaction rate	163(63.4)	88(34.2)	6(2.3)
21	Discharging the body of deceased person by the discharge unit can cause a high dissatisfaction rate	163(63.4)	85(33.1)	9(3.5)
22	The delay of Payment Counter at the time of discharge can cause a high dissatisfaction rate	155(60.3)	86(33.5)	16(6.2)
23	One of the problems of bereaved relatives is related to the financial and economic issues when discharging the deceased person.	168(65.4)	84(32.7)	5(1.9)
24	Lack of a gathering hall can cause a high dissatisfaction rate	139(54.1)	111(43.2)	7(2.7)
25	Lack of catering facilities for the bereaved relatives can cause a high dissatisfaction rate	140(54.5)	112(43.6)	5(1.9)
26	Lack of a guide for discharge affairs can cause a high dissatisfaction rate	154(59.9)	95(37)	8(3.1)
27	The problems related to delivering the deceased person's body from the morgue can cause a high dissatisfaction rate	111(43.2)	138(53.7)	8(3.1)
28	The problems related to preparing an ambulance can cause a high dissatisfaction rate	133(51.8)	108(42)	16(6.2)
29	The security guard's bad behavior can cause a high dissatisfaction rate	99(38.5)	151(58.8)	7(2.7)

Table 3. The medical staff's agreement rate based on the questionnaire domains

Domain	Items	%		
		Agree	Disagree	No answer
Welfare	4.5, 6, 10, 11, 12, 13, 14, 15, 20, 21, 22, 23, 24, 25, 28	67.97	29.23	2.8
Support	3, 7, 8, 9, 17, 18, 19, 26, 27, 29	52.29	45.04	2.67
Communication	1, 2, 16	68.9	30.33	0.77

Current Psychosomatic Research

More than 90% of bereaved families stated that they needed to be with their patient in the ward during his/her end-of-life moments. More than 90% agreed that there is a need for a separate unit in the hospital to deal with the affairs of the deceased person and that this unit should support them to assess their mental and emotional state. About 97% agreed that if the families do not have enough money at the time of discharge, they should accept the deceased person's ID card and discharge him/her. About 94% reported the need to receive transportation services at the discharge unit (Table 4).

The mean score of the questionnaire surveying the perspective of bereaved families was 66.04 ± 6.97 , ranging 52-86. The highest agreement rate was related to the support domain, followed by communication and welfare dimensions, while the highest disagreement rate was related to the welfare domain, followed by communication and support domains (Table 5). In examining the difference in the mean scores of this questionnaire based on the demographic characteristics of bereaved families, the results of the Mann-Whitney U test showed no statistically significant difference between males and females ($P=0.126$). Based on the Kruskal-Wallis test, there was no statistically significant difference based on the marital status ($P=0.176$), occupation ($P=0.355$), or relationship with the deceased person ($P=0.640$). However, this difference was statistically significant in terms of education level ($P=0.026$) (Table 1). Based on the Spearman correlation test, age had no statistically significant relationship with the questionnaire score ($P=1.000$).

Discussion

Based on the results of the present study, the perceptions of bereaved families and medical staff regarding the needs and problems of bereaved families in the hospital were almost similar and at an moderate level, indicating the bereaved families' challenges in dealing with the deceased person's affairs and they need supportive measures and targeted interventions from the relevant authorities to address their needs and problems. A statistically significant difference was found in the perceptions of families based on

educational level; people with a higher level of education have a greater ability to recognize and express the needs and problems of bereaved families due to greater access to information resources, better coping skills, or a deeper psychological understanding of the grieving process. Also, a statistically significant difference was reported in the perceptions of medical staff based on age, work experience, and gender, which indicates the effect of these factors (age, work experience, and gender). Older and experienced medical staff, due to higher knowledge and experience, previous experience of dealing with the bereaved families, and higher skills in dealing with psychological issues, have a deeper perception of grief and achieve a better understanding of the needs of the grieving families. Differences in perspectives of medical staff based on gender can be due to different reactions, perceptions, and characteristics of men and women.

In the present study, we assessed the perception of both groups of bereaved families and medical staff regarding the needs and problems of bereaved families in three dimensions of welfare, support, and communication. According to the results of the present study, the need for a separate unit in the hospital to deal with the affairs of the deceased person, the need for a bereavement room in the hospital for bereaved relatives that provides catering services, and the need for transportation services for bereaved relatives in the discharge unit were among the needs perceived by bereaved families which were related to the welfare dimension. Wandering and wasting time to access an ambulance to transport the deceased person, to discharge the deceased person from the discharge unit, to perform payment check-outs in the Payment Counter, and to discharge the deceased person from the morgue were among the problems perceived by bereaved families, which were also related to the welfare dimension. Therefore, the prolonged process of settlement and delivering the deceased person's body creates additional psychological pressure on families.

The medical staff mentioned the presence of the patient's first-degree relatives in the end-of-life stage, the

Table 4. The items for the questionnaire surveying bereaved families' perspective of their needs and problems

No.	Items	No. (%)		
		Agree	Disagree	No Answer
1	The medical staff do not neglect the patient's treatment	97(95.1)	5(4.9)	0
2	The medical staff treat the deceased person well	98(96.1)	4(3.9)	0
3	The medical staff treat the bereaved relatives well	98(96.1)	4(3.9)	0
4	The medical staff properly informed the relatives about the patient's death	95(93.1)	7(6.9)	0
5	The relatives prefer to be informed about the patient's death by the supervisor or the nurse.	93(91.2)	8(7.8)	1(1)
6	The relatives prefer to be informed about the patient's death by the Unit of Decedent Affairs.	92(90.2)	6(5.9)	4(3.9)
7	The way of transferring the deceased person's body to the morgue is suitable	93(91.2)	8(7.8)	1(1)
8	The way of delivering the deceased person's body from the morgue is suitable	92(90.2)	9(8.8)	1(1)
9	The relatives are allowed to grieve in the ward	88(86.3)	11(10.8)	3(2.9)
10	The ward has full cooperation in discharging the deceased person without any delay.	74(72.5)	25(24.5)	3(2.9)
11	The relatives spend a long time in the Payment Counter to do the deceased person's affairs which waste their time	55(53.9)	47(46.1)	0
12	The relatives spend a long time in the discharge unit to do the deceased person's affairs which waste their time	54(52.9)	48(47.1)	0
13	The relatives spend a long time in the morgue to do the deceased person's affairs which waste their time	56(54.9)	46(45.1)	0
14	The relatives wait a long time for an ambulance to transfer the deceased person which waste their time	49(48)	51(50)	2(2)
15	The security guard treats the bereaved people well	67(65.7)	33(32.4)	2(2)
16	Preparation for the delivery of deceased person's body put a high mental and emotional pressure on the relatives	63(61.8)	37(36.3)	2(2)
17	The relatives need a bereavement room in the hospital	70(68.6)	28(27.5)	4(3.9)
18	In the bereavement room, catering facilities should be prepared for the bereaved relatives	70(68.6)	30(29.4)	2(2)
19	Seeing the deceased person should be done in the bereavement room	79(77.5)	21(20.6)	2(2)
20	The deceased person's body should not be transferred to the morgue.	75(73.5)	24(23.5)	3(2.9)
21	The relatives need a chaplain for receiving psychological support in the hospital.	88(86.3)	11(10.8)	3(2.9)
22	A separate unit is required for managing the deceased person's body affairs in the hospital.	94(92.2)	6(5.9)	2(2)
23	The deceased person's ID card should be accepted for discharge if the relatives do not have enough money	99(97.1)	2(2)	1(1)
24	The transportation facilities should be prepared for the bereaved relatives in the discharge unit	96(94.1)	5(4.9)	1(1)
25	The relatives should stay beside the patient in the end-of-life stage.	98(96.1)	3(2.9)	1(1)
26	The Unit of Decedent Affairs is required to support the relatives until they have a emotionally stable condition.	97(95.1)	3(2.9)	2(2)

Table 5. The bereaved families' agreement rate based on the questionnaire domains

Domain	Items	Agree (%)	Disagree (%)	No Answer (%)
Welfare	10, 11, 12, 13, 14, 16, 17, 18, 19, 22, 24	67.71	30.67	1.62
Support	1, 9, 20, 21, 23, 25, 26	89.92	8.25	1.83
Communication	2, 3, 4, 5, 6, 7, 8, 15	89.22	9.67	1.11

Current Psychosomatic Research

presence of a chaplain to provide emotional comfort to the families, the existence of a separate unit in the hospital (unit of decedent affairs), and the presence of a gathering hall in the hospital to avoid seeing the heartbreaking scenes, as the needs of the bereaved families which were related to the welfare dimension. The medical staff also mentioned the time-consuming process of the discharge of the deceased from the ward (due to delays in visiting doctors to write a summary of the case and issue a death certificate, delays in issuing a burial permit, and referring the deceased to the Forensic Medicine Organization), time-consuming process of payments for the discharge of the deceased from the discharge unit, financial and economic problems of families for the discharge of the deceased person, the lack of a bereavement room in the hospital with catering facilities, and the problems of families for finding an ambulance as the most important problems of the bereaved families which were also related to the welfare dimension.

Gray et al. [9], in a survey of bereaved families, categorized the results of the study into three areas: patient needs (maintaining health, appropriate medication prescription, adherence to patient wishes, physical presence in the patient's final hours of life, and spiritual and religious end-of-life care), family and caregiver needs (enhanced communication with the patient's care team, assistance with administrative challenges after death, emotional support, respect and valuing the patient's life), and organizational facilities and characteristics (optimal staff care team coordination, presence of non-clinical staff for care, optimization of catering services, equipment and facilities for people with disabilities, provision of high-quality food), most of which are consistent with the results of the present study. Giorgali [14] in a study on the needs of bereaved families for bereavement services after the death of a child with cancer in Greece, stated that continuity of bereavement care from the care team, availability, individual care, an interdisciplinary approach, and contact with other bereaved parents were the key elements for providing bereavement services. In Boven et al.'s study [7], the provision of in-hospital bereavement services was also described as a caring be-

havior and challenge, and bereaved relatives appreciated all the services provided during bereavement. However, service providers, while recognizing the importance of bereavement care, stated that the provision of this care was challenged by several factors, such as insufficient training and time constraints. The results of Kruse et al.'s study [15] on supporting bereaved family members in the loss of children or adolescents also showed that grief counseling should be considered an essential component of health care for bereaved family members, because from the participants' perspective, this counseling led to their comfort, adaptation, and faster return to daily life. The results of these studies are consistent with some of the results of the present study. Policymakers in Iran should be able to adopt policies using the experiences of the medical team for the bereaved families and take effective measures to provide welfare facilities, counseling services, and administrative and financial assistance to the bereaved families.

Among the needs and problems perceived by the bereaved families related to the support dimension, the need to be present in the ward during the patient's last hours of life, the failure to transfer the deceased person to the morgue, the need for the Unit of Decedent Affairs to support them and assess their mental and psychological states, the need for a chaplain to be present in the hospital to provide mental and psychological support to the bereaved families, the need for a social worker to be present after the patient's death, and acceptance of a valid ID card if the families did not have enough money to discharge the deceased person. In the present study, most of bereaved families stated that they had full support by medical staff in terms of performing procedures and they did not delay the time of discharge from the ward. The medical staff's perceptions related to the support domain included: Families' ability to meet the deceased person in the ward, the presence of a guide during the discharge of the deceased from the hospital, the presence of only one first-degree relative during the transfer of the deceased from the ward to the morgue, the unwillingness of the bereaved families to transfer the deceased person's body from the ward to the morgue, as well as the obser-

vation of the resuscitation stages and the patient's death by the patient companions.

In line with these results, several studies have indicated the need for emotional support for bereaved families. Thaqi et al. [16] showed that bereaved family members were satisfied with the patient's end-of-life care. Information about the grief process and grief-related services was considered useful from their perspective. Researchers believe that the family should be considered as a unit to provide the opportunity for togetherness, mutual reflection, meaningful relationships, preparation for death, and resilience. Ito et al. [17] reported that the support and care needs of service providers such as lack of privacy due to poor design of the emergency department and presence during resuscitation, chaotic environment, and psychosocial reaction in grief, were the challenges in providing support and care to bereaved families, which indicates that emergency nurses need to better understand the experience of bereaved families. In the study by Kalocsai et al. [13] in Canada, nurses and physicians supported the provision of empathetic services to bereaved families. Emotional support is a vital type of support that clinicians are usually unable to provide to bereaved families due to having multiple tasks and responsibilities. Also, the results of Ó Coimín et al. [11] in Ireland showed that, although the quality of care provided by nurses, doctors, and other staff to bereaved families was highly rated, care in areas such as communication, emotional, and spiritual support still needed to be improved. Naef et al. [8] stated that there are many barriers to bereavement care in hospitals, and more research is needed to better understand the barriers and facilitators in the provision of bereavement care. They stated that a need-based guideline to the provision of bereavement care in hospitals is necessary to include the best practices and organizational support required. Also, according to the results of Aoun et al. [18] in Australia, a large gap is observed between the care services provided and the existing guidelines, which indicates that more research is needed in the field of underlying attitudes and patterns of bereavement support. In addition to developing guidelines, positive attitudes of service providers towards these guidelines and the participation of beneficiaries in sharing their experiences in the field of quality service provision are needed to modify the existing guidelines.

Regarding the communication dimension, most of the bereaved families agreed with the appropriateness of the treatment of the medical staff, the way of informing the patient's death, and the way of transferring the deceased person from the ward to the morgue. The medical staff mentioned the difficulty of informing the families about

the patient's death and the need for a liaison officer in the hospital to inform the families about the patient's death as the problems and needs related to the communication dimension. Haugen et al. [12] examined the perspectives of bereaved families in seven European and South American countries, and the results showed that there were many services available to provide care to dying patients, but there was still a need to improve skills in dealing with bereaved relatives. This suggests that communication challenges are not unique to a specific country; medical staff in all countries, even in those with advanced health systems, need to improve their communication with bereaved families. According to Aoun et al. [18], providing timely services and establishing effective communication play a crucial role in building trust in the services and focusing on the specific needs of bereaved families, rather than their general needs. In the study by Ito et al. [17], providing insufficient information and inappropriate transmission of bad news by medical staff were one of the care challenges raised by bereaved families. Most of the issues raised in these studies were also reported in the present study. However, there are some discrepancies that can be attributed to ethnic-cultural differences and varying family expectations across different cultures. For example, in the study by Ito et al. [17] only the experiences of bereaved people in the emergency departments were surveyed, where the conditions and emergency services, the anxiety of patient companions, and the lack of psychological preparation to accept bad news are different, which can be considered negative experiences for bereaved families. Overall, bereavement-related problems are a significant health issue, but there is lack of economic resources and investment for effective implementation of integrated bereavement care services at national levels [19]. Individual, family, and community-related indicators should be aligned with traditional medical indicators, respecting local cultures and contexts, to ensure that care systems are not only equitable but also responsive to diverse needs [20].

The limitations of this study included a small sample size and the risk of response bias due to the use of self-report tools, and the poor mental conditions of bereaved families and medical staff, which may affect their response to the questions. We offer the following policy recommendations based on the results of the present study:

I) Develop and implement comprehensive guidelines for caring for bereaved families and monitor their implementation:

1) focus on counseling and supportive services; 2) Provide information clearly that is understandable to the bereaved families, taking into account legal requirements and confidentiality of their information; 3) determine the level of family caregivers' involvement in the end-of-life stage; 4) provide adequate information on the limitations of palliative care; 5) support according to the needs of bereaved families in a safe and ethical manner.

II) specialized communication training for medical staff, especially in the field of bereavement care:

1) issues related to grief should be included in the educational programs of medical staff; 2) necessary training should be provided to all medical staff on how to inform the bereaved families about bad news; 3) by improving appropriate communication between the doctor and the patient's companions, timely information about the condition of the critically ill patient should be provided in an understandable and clear language.

III. Improving the welfare facilities in the hospital:

1) A quiet place with appropriate welfare facilities should be provided in the hospital for bereavement and the gathering of bereaved families; 2) the method of providing information and access to transportation and ambulance services for the transfer of the deceased person should be clarified in coordination with the relevant units.

IV. Facilitating administrative and financial processes related to the discharge of deceased people.

V. Establish specialized units and interdisciplinary teams for end-of-life care and bereaved families:

1) A team to deal with the affairs of deceased people, led by a trained person, should be established in the hospital to reduce the problems of the bereaved families; 2) trained personnel should be assigned to resolve the issues related to deceased individuals and carry out administrative procedures to achieve greater satisfaction with the provision of hospital services.

Pay special attention to spiritual and cultural support:

1) conditions for access to a chaplain should be provided to comfort the dying person and the bereaved families based on their religious beliefs and cultures; 2) medical staff should be aware of the cultural and spiritual sensitivities to death and bereavement, and facilities should be provided in the hospital to implement spiritual and religious programs. Designing interventions to respect

the human aspect of care: An effort should be made to include issues related to grief and support for bereaved families in the educational and cultural programs of medical staff.

Conclusion

The results of the present study indicate that the problems and needs of bereaved families in hospitals are multidimensional. It is necessary to pay attention to the welfare, support, and communication dimensions of these problems and needs for bereaved families. Ethnic, cultural, and environmental differences, as well as individual differences, should be considered in the design of comprehensive interventions, as these differences have a significant impact on supporting bereaved families.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of [Mazandaran University of Medical Sciences](#), Sari, Iran (Code: IR.MAZUMS.REC.1394.H102). Verbal consent was obtained from the participants. They were assured that their information would be kept confidential. All ethical principles were considered in the present study.

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Authors' contributions

All authors contributed equally to the conception and design of the study, data collection and analysis, interpretation of the results and drafting of the manuscript. Each author approved the final version of the manuscript for submission.

Conflict of interest

The authors declared no conflict of interest.

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