Grief Hospitality Program

by
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Executive Summary

Trauma centers and intensive care units at healthcare systems across the country provide care to patients who have been involved in traumatic, life-threatening accidents. These patients have access to the best care and resources healthcare systems have to offer. On the other hand, families of these patients, some of whom are actively dying because of the traumatic event that occurred, are not receiving any type of care or resources to help them throughout the patients' hospital stay or grief support after the patient has died. The experience that family members have with their dying loved one at the end of life will be remembered long after their loved one dies. The Grief Hospitality Program, which can be implemented at any healthcare system, would provide services to families of actively dying patients who suffered a traumatic accident. Services provided could include private family rooms, food and beverages, hotel accommodation support, parking validation, grieving and bereavement resources, supplies from a comfort cart, and post-hospitalization follow-up. Similar programs are provided at healthcare systems across the United States and have found to be utilized and appreciated by the grieving family members resulting in a more positive healthcare experience, considering the situation.

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Part I – Theoretical Background

Background

"Grief is a strong, sometimes overwhelming emotion for people, regardless of whether their sadness stems from the loss of a loved one or from a terminal diagnosis they or someone they love have received" (Mayo Clinic, 2019b). Every person is affected by grief differently based on the relationship or circumstance and what caused the grief. Below are some common causes of grief, examples of emotional and physical symptoms associated with grief, and complications of grief, based on an article written by Dr. Kannan and reviewed by Dr. Krishan Kumar Sharma.

Table 1: Causes, Symptoms, and Complications of Grief

Common Causes of Grief	• Death of a loved one • Divorce • Any illness • Miscarriage • Loss of friendship / job • Retirement
Emotional Symptoms of Grief	• Irritability • Numbness • Bitterness • Detachment • Inability to show joy • Problems in accepting reality • Losing the sense of purpose • Lack of trust
Physical Symptoms of Grief	• Improper digestion • Weakness • Headaches • Chest pain • Muscle soreness
Complications of Grief	• Depression • Suicidal thoughts • Anxiety • Post-Traumatic Stress Disorder (PTSD) • Sleep disturbances • Heart disease • High blood pressure • Alcohol and substance abuse

(Sharma, 2020)

“Everyone grieves differently, you may cry, get angry, feel withdrawn, or feel empty, but with the right support and by getting help at the right time, you can heal” (Sharma, 2020). Grieving during the Coronavirus Pandemic, also known as COVID-19, has been very difficult for many people. “Death from COVID-19 is often sudden and unexpected. Restrictions in place because of the pandemic have changed the experience of dying. Health care systems have implemented stringent limits on visiting ill patients. In acute adult inpatient settings, permission to visit in person may be granted to a loved one only briefly or not at all. As a result, it is healthcare professionals, support staff, or chaplains, and not family members, who are by the sides of dying persons. Often, too, these healthcare personnel are wearing personal protective equipment, which limits their ability to connect with their patients. These difficult circumstances increase the burden for family members dealing with the loss of a loved one during this pandemic. Comprehending the reality of a loss is difficult under any circumstances, but even more so when the death is sudden and a loved one is left to die alone” (Goveas & Shear, 2020, p. 1120). As shown below in Figure 1, patients were saying goodbye to their loved ones through IPads, computers, or other forms of technology because of the visitor restrictions at most healthcare organizations. Some patients did not have the ability to say goodbye to their loved ones because they lacked capacity or died suddenly in a traumatic accident. The families of these patients are likely experiencing many of the symptoms and complications of grief discussed above.

Figure 1: Alone and Dying

(Bergeron, 2020)

Heart disease, cancer, and unintentional injuries caused by an accident are the three leading causes of death in the United States (Centers for Disease Control and Prevention, 2021). Cases where a person suffers a traumatic injury would fall under unintentional accidents. "Trauma is a leading cause of death and disability in the United States and is the number one cause of death from age 1 to 46 y. One out of every 10 deaths is trauma related, and many victims are previously healthy" (Bhangu et al., 2020, pg. 2). Often times, those who are involved in a traumatic accident suffer from traumatic brain injury, or TBI. "Approximately 1.4 million Americans sustain a traumatic brain injury each year, and of these, 1.1 million are treated and released from the hospital, 235,000 are hospitalized and 50,000 die. The leading cause of brain injury is falls among those between the ages of 0 and 4, and those over the age of 75. Other common causes of traumatic brain injury are motor vehicle accidents, being struck by or struck against a moving or stationary object, and assaults and other physical violence. Motor vehicle accidents is the cause most likely to result in

hospitalization" (Newsome Melton, 2016). There are different levels of traumatic brain injuries, including mild traumatic brain injury and moderate to severe traumatic brain injury (Mayo Clinic, 2021). While there are many risk factors and complications when someone suffers a traumatic brain injury, as mentioned above, a large number of people die from traumatic brain injuries every year.

Literature Review

The purpose of the Grief Hospitality Program is to provide services to families of actively dying patients who do not have access to certain items because of rushing to the hospital to be with their loved one. Along with necessary items, research also shows that these family members benefit from post-death resources given to them by the hospital staff. The information identified below was found through a literature review that could be beneficial to the Grief Hospitality Program based on what other organizations or individuals have done in the past. There are also impact statements throughout the document from the literature indicating how other organizations and/or individuals had similar experiences or feedback from those experiences.

Services other organizations have provided:

Communication Services

Communication has been a very universal service that many organizations or clinicians use at all times but are especially used during situations when a patient is dying. One may not think of communication as a typical "service" because it should be provided through any type of quality healthcare; but these compassionate conversations take a certain type of person and not all clinicians are capable of having such conversations with families. Aspects of these conversations, frequently performed by Social Workers or Chaplains, should include making the family feel validated and well as gauging their emotion needs. The "Griev_ing Pneumonic" is a technique used mostly by first responders and is a step-by-step guide to help with death notifications to families. Studies have shown that families appreciate straightforward details about their loved ones prognosis and prefer that the medical staff avoid using euphemisms, as they tend to be confusing to families. A service, referred to as a "Chaperoning System", is sometimes used for a

smoother transition of communication between the medical team and the family. The role of this middleman is typically played by a Chaplain or a Social Worker, who understands enough of the patient's condition, as well as can communicate in a meaningful way with the family.

Allowing Families in Patient Rooms

Allowing family members in the patient's room is another service that is offered that some might think should be included in quality healthcare. The Trauma Center is a different atmosphere than any other part of the hospital and allowing visitors in the rooms is far more difficult than in other parts of the hospital.

Family Care Conferences

A family care conference is offered quite often to the patient's families when goals of care need to be discussed. Learning more about the personal life of the patient, quality of life up until the accident, quality of life post-accident, and next steps to be taken are all things that are typically discussed during a family care conference. Research shows that the sooner the family care conference occurs, the better the patient's family will adapt to the situation and the patient's care could benefit as well. These care conferences often include the multidisciplinary teams involved in the patient's care.

Bereavement/Grief Resources

Prior to families leaving the hospital after their loved one passes, they will receive bereavement/grief resources. These resources will include information about local support groups, where and how to meet other families who have experienced a similar death, follow-up

bereavement/grief counseling, etc. Other organizations have customized these resources to better fit the families who will be utilizing them. For example, if the patient was a child, resources should reflect support groups for loved ones who lost a child, sibling, etc.

Comfort Carts

Comfort carts are being used by many organizations as a service offered to patient's families. While these are sometimes more common in pediatric hospitals (or comfort carts with items for patients), they can be altered to use in adult facilities as well as for the patients' families. Items that are included in comfort carts (or a part of the service) could include many products such as toiletries, snacks, reading materials/cross word puzzles, playing cards, socks, blankets, hand molding kits, ECG strips, etc.

Private Room

Some organizations have provided families with a separate space in the hospital for them to be alone and grieve. These private rooms for family are also often used when a family care conference needs to occur with the medical team.

Why these services are important:

Communication Services

Death by traumatic injury accounts for 10% of deaths in the United States. Not only has the patient faced a traumatic experience, so has the family who more than likely did not expect their loved one to die suddenly. "Population-based studies in the US show that unexpected death of a loved one is the most frequently reported potentially traumatic experiences making mental health

consequences of unexpected death an important public health concern" (Keyes et al., 2014, pg. 2). Passionate conversations between the medical team and families have been proven to help families of dying patients start the grieving process sooner, sometimes before they even leave the hospital. This can be extremely beneficial to the families because they will have more access to resources for grieving, PTSD, etc., prior to leaving the hospital. The "Chaperoning System" is important because sometimes the medical team, although they are great clinicians, are not experienced or the best communicators. The Chaplain or Social Worker, whoever is working as this intermediary, are usually trained to have difficult conversations with family and will more than likely be consoling and understanding of the family.

Allowing Families in Patient Rooms

There is a good amount of research around the debate of whether or not it is appropriate to allow families in patient rooms. Concerns arise regarding whether or not the patient, who more than likely lacks capacity, would want their family to see them in their current state.

Family Care Conferences

Family care conferences are important to ensure the family understands their loved one's goals of care and knows what to expect moving forward. The family care conferences are also beneficial to the team to be sure they are all on the same page.

Bereavement/Grief Resources

Providing families with resources before they leave the hospital is so important to ensure they are given the chance to get as much support as possible. There is no way of knowing how a family

member will grieve after the sudden death of a loved one; so giving them multiple resources could be beneficial to them as they may find that one or all of them will help get them through this tough time.

Comfort Carts

Research shows that the usage of comfort carts, or similar concepts, reduce the feeling of anxiety and helps to improve relaxation. Items included in the comfort carts are provided to families who have rushed to the hospital to be by their loved one's side; thus, they may not have toiletries or easily accessible snacks. Other items, such as hand molding kits or the ECG strips, are offered as a keepsake to remember their loved one.

Private Room

Conference rooms or a private space dedicated for families is an important thing to have available because these families need a separate space to be able to talk through the tragic event that just occurred, without being around strangers in a waiting room. This dedicated space would allow a quiet room for them to rest, grieve, and have meaningful conversations with the medical team.

Family reactions to services:

There is limited research indicating the families' reaction to certain services that were offered. Studies shows that nurses do not always include the families support in the care of their patients, even though they acknowledge the importance of it. When families are included in the patient care, it tends to be focused on how to support the patient; not how the family can and should be supported or how they are feeling throughout the process (Luttik, 2020, pg. 660). Most family

members would prefer to be present in their loved ones hospital room so being allowed or not being allowed to be in the room, could have a large impact on the families' perception of care after the fact. Families often have a positive experience with services of the "Chaperoning System" as they are appreciative of the Chaplain or Social Worker explaining things to them and having meaningful conversations. Family care conferences are shown to decrease PTSD symptoms, anxiety, and depression in family members because the medical team is able to establish a relationship with them as well as communicate the goals of care. Families are often appreciative of the resources that are given to them prior to leaving the hospital. There is no way of knowing if these resources are being used, so future research should be completed to determine if resources are beneficial or if they go unused. Families who utilize the items in a comfort cart often find themselves able to relax more easily mentally and physically, especially if they are able to do so in a separate room that the hospital has provided. Families appreciate the dedicated space provided to them because they feel more comfortable in a private room to be open with the medical team and research shows that these families are able to start the grieving process before even leaving the hospital when space to do so in provided.

Problem Statement

As stated above, unintentional accidents resulting in trauma injuries are one of the leading causes of death in the United States and mostly affect those between the ages of one to forty-six years old. While there are many services provided to the actual trauma patient, there is very little research showing there are services available to the families of actively dying trauma patients. “At the end of the day people won’t remember what you said or did, they will remember how you made them feel.” (American Nurse Today, 2019). Offering comfort measures to these family members will help to improve their experience in the hospital. While it is important to the healthcare organization for the families to have a positive experience while in the hospital, providing comfort measures to families to ensure they are as comfortable as possible is more important. If families are treated well and feel like they are being heard and are appreciated, it will more than likely result in a positive experience in the hospital, considering the circumstances. Many families of patients who were involved in a traumatic accident rush to the hospital, sometimes from out of town, and do not have the basic supplies needed to spend an extended period of time in the hospital, such as toiletries. Along with the absence of necessary hygiene supplies, there is also a need for other services of support, such as grief/bereavement resources after a loved one dies, food/beverage, etc., for families of actively dying patients. Families of trauma patients often feel confused and alone while in the hospital at bedside of their loved one. In relation to the legacy building activities that Stephani Haug implemented at the organization where she was employed, “Haug says these small acts of kindness went a long way with the families. It is very important for our families to know that we acknowledge their loss, and I want them to know they are not alone” (Harris, 2019). These traumatic accidents are sudden and unexpected and there is a need to provide comfort measures to families of patients who are

involved in an accident such as this. The proposition would be that the Grief Hospitality Program could offer these comfort measures and resources to families of trauma patients who are at the end of life.

Part II – Grief Hospitality Program

Introduction of Grief Hospitality Program

The objective of the Grief Hospitality Program offered at Indiana University Health in their Level I Trauma Center will provide support to actively dying patients' families who are in the waiting areas for an extended period of time. The program will also provide services to those family members who are from out of town and need additional help in finding lodging while they are in town. The reason the Trauma Center for the area of focus for this program is because the Trauma Center is different from the emergency department. "At IU Health, our Trauma Centers provide advanced, comprehensive care for traumatic injuries. We give patients access to more resources and technology than they can receive in an emergency department. Trauma refers to damage that the body sustains from an external force. Potential sources of trauma include automobile accidents, falls, and knife and gunshot wounds. Examples of trauma include:

- Multiple fractures
- Acute spine injuries
- Punctured lungs
- Stab wounds
- Brain injuries

Fewer than 10 percent of U.S. hospitals have a Trauma Center. Fortunately, only a few patients have injuries severe enough to need these services. Most injuries can be treated in a typical emergency department or, in the case of milder strains and pains, at a primary care office or urgent care center. When you have traumatic injuries, the right care at the right time can be lifesaving" (Indiana University Health, *Level I Trauma Center*). While comfort carts are typically offered to ICU patients, the argument is that comfort carts could also provide support to the families' of actively dying patients. Stephani Haug, a nurse in the Neuroscience ICU at Augusta University

Health, made the following statement after she implemented “The Butterfly Cart”, which is their version of a comfort cart, “many of our families rushed to the hospital with their loved one and did not have a chance to grab things like toothbrushes, and the cart is there to provide families with those basic resources,” (Harris, 2019). “When families reach my unit, they are usually in a bad state emotionally, and we can at least give them some of the items they need. People can really feel when you care, and I feel this added touch will make such a difference during a very difficult time,” said Lawhead, AU Health’s Patient and Family Centered Care Coordinator (Harris, 2019). Throughout this paper, team members and the medical team are referred to as those who will benefit or use the resources provided by this program. The “medical team” are those directly related to the patients care. “Team members” are those who are not on the medical team but work for the same organization and should be aware of the program.

Program Overview

The focus for the Grief Hospitality Program is that it would be implemented at Indiana University Health, Methodist Hospital Level I Trauma Center. This program will provide support to families who had a close family member who was involved in a traumatic accident and is actively dying. In 2019, the volume at the Methodist Hospital Trauma Center was 3,352 patients. This number accounts for all traumatic accidents, including falls that resulted in a bump on the head. As mentioned above, the focus of this program will be on the families of traumatically injured patients' who are actively dying. In order for the program to be successful, the Executive Director, Program Director, and the On-Call Nurse Leadership will work together to determine which families will receive the support measures offered by the program. Ultimately, the medical team working with the patient and their families will see what kind of distress they are facing and will then take their concerns to the On-Call Nurse Leader. The On-Call Nurse Leader will then determine what support measures the family should receive. These supportive measures could include, but are not limited to, private rooms for the families, meals, arranging hotel accommodations, validating parking, and offering comfort cart supplies. Grief/bereavement resources and post hospitalization follow-up should be provided to all families of the patient. Costs of giving families these resources are very minimal and should always be provided to assist in their current state after losing their loved one.

Services Provided

Private Room / Family Waiting Rooms

"Social workers identified the need for a single or private room at end of life, not only to offer patients' a sense of privacy and dignity during the dying process but also to allow their families a

safe space to express sadness and grief" (Moon et al., 2019). The private rooms, or family waiting rooms as referred to by other hospitals, are provided so the family does not have to constantly be in the patient's room or in the waiting room and can "get away" to a private room to grieve or have conversations with others. This room could simply be a conference room that is close to the patient's room or any other type of unoccupied, private space.

Immediate Family Presence in Patient Room

There is also research around allowing immediate family members in patient's room. Immediate family members would include spouse, children, and additional people of spouse/children's choosing if the medical team approves. There are definitely some downfalls to immediate family being in the patient's room but there is belief that the benefits outweigh the burdens. The following quote is one advantage that was found from the family being in patient's room, "A randomized controlled trial found that relatives who had the opportunity to witness CPR had significantly lower rates of symptoms of posttraumatic stress disorder (PTSD) than those who did not, while relatives who did not witness CPR experienced more depression and anxiety than those who did. Those relatives who were offered the opportunity to be present during CPR had less intrusive imagery, post trauma avoidance behavior, and symptoms of grief when assessed three months and one year later. Witnessing resuscitation can inform the family about the severity of their loved one's condition and can provide reassurance that all measures were taken to save the patient's life. In the event that the resuscitation is not successful, being present can facilitate the grieving process for the family by allowing the opportunity for a last goodbye, aiding in closure and bringing a sense of reality to the loss so as to avoid a prolonged period of denial" ("Should Family Be Permitted in a Trauma Bay?," 2018, p. 457). Administering CPR may not happen for all trauma

patients, but there is always a chance that this can occur with the family in the room. While most clinicians will probably pushback on this service because they believe the family could interfere with the care of the patient, some will find that it truly does help one in the grieving process.

Food and Beverage

When it comes to providing food and beverages, leadership can work with in-house catering or the cafeteria to have food delivered to the private room for the family. This could be simple snacks such as fruit, individual bags of chips, and water and/or coffee or they could provide meal vouchers to the family, so they can go to the cafeteria to get a hot meal of their choice. Often times, people do not want to or do not feel like eating when facing a traumatic experience – having food or snacks readily available for them may entice them to eat since they will not need to go out and seek food. Families often do not want to leave their loved ones side; so providing this service to the family could prove to be very meaningful.

Hotel Accommodation Support

One cannot always assume that the patient's family lives locally. If this service is needed, the On-Call Nurse Leader should contact the Program Director to have them work with the family and guest services, or the information desk, to ensure there is someone who can help with reserving any hotel rooms for the patient's family. Although the price of the hotel might not be covered by the hospital or program, the convenience of having someone who knows the area and can provide support when booking a hotel room could be very beneficial to a grieving family member. Indiana University Health has contracts with nearby hotels in downtown Indianapolis offering discounts for guests who book through Indiana University Health. This partnership could be very beneficial

for this program. As the program builds its community relationships and donations start flowing in, there is an opportunity for hotel costs to be covered for families by the program.

Parking Validation

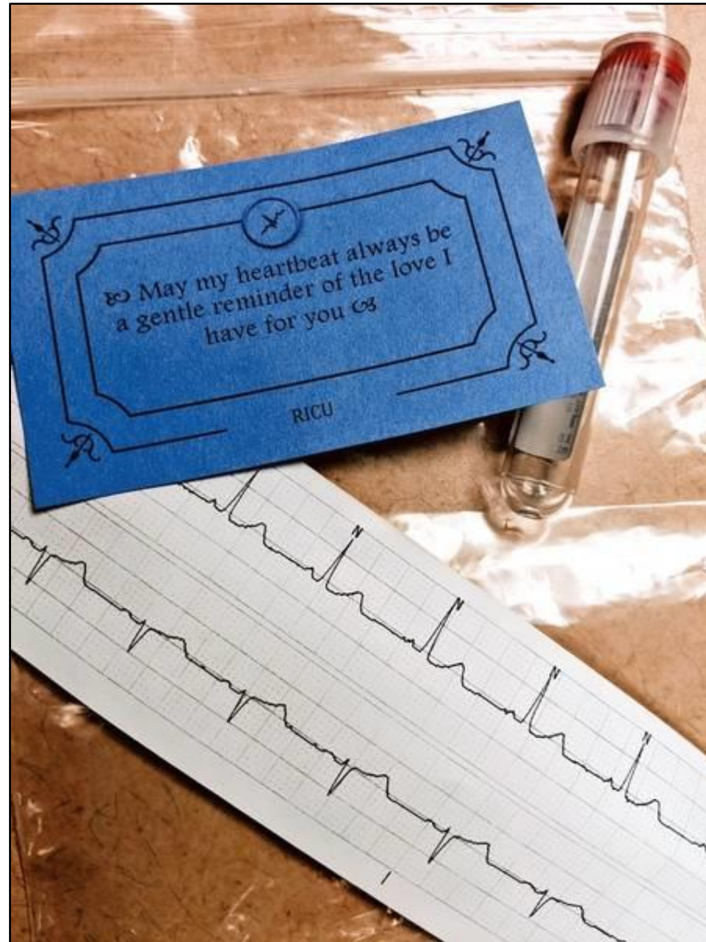
While not all hospital systems require patients and visitors to pay for parking, this should be provided at the hospitals that have parking garages or other paid parking lots. The On-Call Nurse Leader will be sure that these family members receive parking validation. This is a simple, inexpensive cost for the hospital to be able to provide to families, so they are not racking up a huge parking expense while at the hospital.

Comfort Cart

"The development of a cart that has items such as refreshments, resource material, and personal belongings provides support for families during near-death transitions. Using the cart, critical care nurses can intentionally create a space that is mindful of the specific needs families and caregivers have as death approaches. The comfort cart can provide a sense of a security that enhances the caring experience" (Stolzman & Connors, 2020, pg. 135). The items in a comfort cart are often provided to the patient but for the Grief Hospitality Program, the comfort cart would provide items of comfort to the patient's family. Gunderman and Nelson said it best in their article titled "Exchanging a Blanket for a Code Blue" posted on *The Atlantic* website, "Often family members of a dying patient feel they can do nothing but stand by helplessly and watch events unfold. The comfort cart provides them something to do, enabling them to turn a sterile hospital room into a more home-like place where they feel less like medical specimens and more like a real family who can do something to help. Its purpose is to create a meaningful, even sacred space around them. It

is not intended to inject an artificial sense of happiness into the situation, but to help people grieve, as they need to, in the way that feels most authentic to them" (Gunderman & Nelson, 2015). The comfort cart will be stored in the Trauma Center and will only be accessible by the On-Call Nurse Leader, Executive Director, and Program Director, but not any of the medical team or other team members. This will ensure that the clinical staff are not accessing the comfort cart at any time to get supplies for their patients or their families. Leaving the comfort cart locked at all times will also help the Program Director track expenses when they return to restock the comfort cart. Items in the comfort cart could include snacks (granola bars, 100 calorie snacks, etc.), lightweight blankets, Kleenex, toiletry kit (including deodorant, toothbrush/toothpaste, comb, face wash), fuzzy socks, activity books (crossword puzzle, word search, etc.), playing cards, and eye masks. Also included in the comfort carts are plaster hand-molding kits. Although this might not be something all families find will bring them ease, others whose family member is near death might find that a keepsake like this could bring them some comfort. Something that other organizations do that could bring comfort to family members would by giving them part of the patients ECG strip. "For the ECG strip we take a screen shot (or scroll through for best possible rhythm of that day), cut out a small section of their rhythm, and roll it into a memory bottle. When presented to the families we tell them they will always have a piece of their loved one's heart" (Brown, 2018). "Legacy Creations", a term used by McMaster Children's Hospital in Canada, consists of memory making items such as hand molding kits, digital stethoscopes, and other items for families (van Halderen, 2020). Figure 2 on the following page is an example of an ECG strip momentum that a Salt Lake City nurse started giving families when their loved one passed away. "Comfort Carts give patients and visitor's tools to reduce anxiety, provide relaxation, and make lasting memories" (Comfort Carts, n.d.). See Appendix I for examples of comfort carts at other organizations.

Figure 2: ECG Strip Momentum



(Abrahams, 2018)

Communicating with the Family

Researchers in New Zealand found that compassionate actions help families of dying patients at the end-of-life. These compassionate actions could be the usage of kind words by the clinicians and hospital staff, taking time with the family, having a quiet space and refreshments. It is important that the clinicians ask the family members questions such as “what is important to them” and “what they are worried about in the moment” (Anderson, 2019). Ensuring that the families are being told about the patient’s status and understand what is going on with the patient throughout

the day is important. In order to have successful communication with the family, the medical team should make sure the family is not just sitting around wondering how the status of the patient. Social Workers and other disciplines, such as a Chaplain, can ensure the families understand what is to come after death such as organ donation, funeral arrangements, death certificates, etc. (Moon et al., 2019). Families need to sense that their feelings are validated. Social Workers are there to talk with families through these hard times and can help to acknowledge the families many feelings. Social workers work through the emotional and psychosocial needs with families (Moon et al., 2019). To communicate effectively with families whose loved one has un-survivable injuries or has just died, Dr. Schiltz suggests the following:

- "Be simple: They cannot process complicated medical information at this time.
- Be honest and transparent: Tell the truth and help them to understand the situation for themselves.
- Be compassionate: Death of a loved one may be one of the worst days of the family members' lives.
- Give them space: The family needs space to process, as they can't hear anything beyond the patient's injuries being un-survivable. They will come to you with their next questions when ready.
- Offer follow-through: Assure the family that even if the patient is transferred, you are there for them in the future" (Mayo Clinic, 2019).

Another type of effective communication between the family and medical team would be a "chaperoning system". This would be done by a Chaplain who would communicate with the medical team and family and essential work as a middleman. "Before entering the bay with family members, the chaperone can assess their willingness to observe, their perceptions about the trauma

bay, their customary coping strategies, their cultural beliefs, and other factors that might affect their experience. He can also identify family members who are overly aggressive or intoxicated or who might otherwise cause significant disruption. Moreover, he can prepare the family beforehand by providing information on the expected procedures and interventions likely to take place and guide the family through the resuscitation while it occurs, answering questions and providing support" ("Should Family Be Permitted in a Trauma Bay?," 2018, p. 459). In order to ensure that the family and medical team are on the same page, family care conferences are often conducted. Family care conferences are typically arranged so that the family and as many of the people on the medical team can meet to discuss the patient's status and their goals of care. "Incorporating family care conferences improves communication and significantly reduces symptoms of PTSD, anxiety, and depression in family members. Showing compassion and respect for family members and their decisions helps to develop supportive relationships" (Benson & Kueakomoldej, 2019). As you just read, the family care conferences are important to discuss the next steps with the patient, but also to assist in the grieving process for family members. Studies show that family members do not need information as much as they need interpretations of the facts of their loved ones' prognosis. With this clearly understood information, family members may be better prepared to make decisions after their loved one passes away (Odgers et al., 2018). Healthcare providers need to avoid using euphemisms, as they tend to confuse family members on the actual prognosis of the patient (Odgers et al., 2018). One last communication technique that might be beneficial when having difficult conversations is called the "Griev_ing Pneumonic". This is a technique, which is below in the chart, that is occasionally used by EMS when making a death calls and could also be used by the medical team when communicating at the end-of-life with the patient's family:

Table 2: "Griev_ing Pneumonic"

G	Gather	Gather the family; all members are present.
R	Resources	Call for support resources available to assist the family with their grief, e.g., chaplains, services, ministers, family and friends.
I	Identify	Identify yourself, identify the deceased patient by name, and identify the state of knowledge of the family relative to the event of the day.
E	Educate	Briefly educate the family as to the events that have occurred, educate them about the current state of their loved one.
V	Verify	Verify their family member has died. Be clear! Use the words "dead" or "died".
[_]	Space	Give the family personal space and time for an emotional moment; allow the family time to absorb the information.
I	Inquire	Ask if there are any questions, and answer as many as you can.
N	Nuts & Bolts	Inquire about organ donation and personal belongings. Offer the family the opportunity to view the body.
G	Give	Give them contact information for resources that can assist them.

(Munoz, 2016)

Post-Hospitalization Follow-Up

Family members may choose to have a follow-up appointment with a Social Worker or other healthcare professional after their loved one has passed away. Healthcare professionals can send home resources and reading materials with the family to assist them in the grieving process. Recommendations can be made to the family if they feel they need to seek grief and/or bereavement counseling along with information about local support groups. The objective is to continue to offer support to the family after they have left the hospital after the passing of their loved one. A follow-up survey can also be sent to the families who used services of the Grief Hospitality Program to receive feedback on the performance of the medical team and the program.

“Contacting bereaved families to express condolences from the local trauma center and share in the family's grief can be a good thing, says Dr. Schiltz. When a patient dies in a trauma situation, we all feel it," she says. "The family needs to know you recognize their family member as a person and not just a number who passed through" (Mayo Clinic, 2019).

Resources for Team Members / Medical Team

While the program largely focuses on offering supportive measures to families of dying trauma patients, there is also a need for resources for the team members and/or the medical team when a patient they were caring for dies. A resource that Indiana University Health offers to their team members is the Employee Assistance Program (EAP). “The IU Health EAP program is a benefit offered by IU Health at no cost to you and your household members. The purpose of the EAP is to help team members cope at home and work and for improved work-life balance” (Indiana University Health, *Employee Assistance Program*). Other healthcare organizations would benefit from a similar program to Indiana University Health’s EAP program. Not only does the EAP program provide services when a team member is having personal struggles, but it will also provide referral and counseling services when team members have a difficult experience on the job. Most people would think that if someone was able to work in the Trauma Center, they should be able to handle the death of a trauma patient. This is not always the situation. Some cases and patients may affect team members or the medical team in ways that others may not, especially in pediatrics. During the Coronavirus Pandemic, some organizations have strict visitor restrictions and are not allowing families in the hospital to visit patients, not matter how critical the patient is. Because patients cannot have their families with them, the medical team is at the patient’s bedside of the end-of-life, more so than they would be if the pandemic was over or never occurred. Team

members and the medical team are spending more time with the patient and are building stronger patient/provider relationships because of these restrictions. This is causing more distress on team members and the medical team than ever before when their patient dies. Everyone is different and reacts differently to circumstances and having an EAP program would be very beneficial for team members.

Resources for Families

"Studies have shown that among ICU patients expected to die within a few days, a proactive family conference and bereavement leaflet resulted in improvements in family symptoms of depression, anxiety, and post-traumatic stress disorder at 3 months" (Kentish-Barnes & Azoulay, 2016, pg. 108). When a patient dies and the family members are getting ready to leave the hospital, they will be provided with a resource packet, which usually comes from the Social Worker who was on the patient's medical team. The following interventions are suggested for families who are grieving:

- "connect families to other parents who have experienced this loss, to self-help organizations, or to professional counseling or services that address this issue;
- provide information in multiple formats (e.g., written, audio/visual, public meeting, broader media programs, Internet based) about the bereavement process including gender differences, expected problems, needs of siblings and extended family, and available services;
- create opportunities for families to meet other families facing similar situations that can make the experience less lonely as well as provide a perspective on the loss

process. This includes connecting parents to self-help groups, especially those that include siblings and extended family services;

- make available professional bereavement follow-up counseling for grieving family members, including individual, family, and/or group;
- bereavement interventions should begin before the loss when it can be anticipated in order to take advantage of the opportunity for preparation and prevention of later adverse reactions" (Institute of Medicine (US) Committee on Palliative and End-of-Life Care for Children and Their Families, 2003, pg. 12).

These resources will be personalized to the family and the patient. For instance, if the patient was a child, the family would receive a packet geared toward bereavement and grieving after the loss of a young child, including local support groups and other community resources. The Center for Complicated Grief has developed a white paper that introduces two helpful acronyms for when one is grieving. The idea came to fruition during the Coronavirus Pandemic to help those through the grieving process. The first acronym is the H.E.A.L.I.N.G. Milestone, which describes milestones that can be reached during the grieving process. This process could be beneficial to family members who have just lost a loved one in a traumatic accident. While one always hopes to strive towards the healing process, there could be "derailers" along the way. Not all people are able to go through the healing process without any setbacks. See below for The Center for Complicated Grief's H.E.A.L.I.N.G. Milestone as well as some common derailers that one might face after the death of a loved one (Shear, 2020).

Figure 3: H.E.A.L.I.N.G. Milestone

Honor your loved one and yourself; discover your own interests and values.

Ease emotional pain; Open yourself to emotions – both painful and pleasant ones; trust that you can deal with emotional pain; it doesn't control you.

Accept grief and let it find a place in your life.

Learn to live with reminders of your loss.

Integrate memories of your loved one; let them enrich your life, and help you learn and grow.

Narrate stories of the death for yourself; share them with others.

Gather others around you; connect with your community, let people in and let them support you.

(Shear, 2020)

Figure 4: Derailers

Doubt that you did enough for the person who died.

Embracing ideas about grief that make you want to change it or control it.

Repeatedly imagining scenarios where the death didn't happen or happened differently, "if only" thinking.

Anger and bitterness you can't resolve or let go of.

Insistent belief that this death was unfair or wrong or shouldn't have happened.

Lack of faith in the possibility of adapting to the loss and having a promising future.

Excessive avoidance of reminders of the loss.

Rejecting support from others, unable to let others help, feeling hurt and alone.

Survivor guilt that is stopping you from experiencing joy and satisfaction.

(Shear, 2020)

There are additional services offered that are similar to what the Grief Hospitality Program offers at many organizations but are not necessarily tied to a program. These services include the following:

- Social Workers express the importance of private rooms for families at the end of life.
- Incorporating family care conferences
- Effective communication strategies such as refraining from using euphemisms.
- Provide bereavement resources to families after their loved one passes.

As mentioned before, all families of actively dying trauma patients will receive a resource folder when they leave the hospital. The H.E.A.L.I.N.G. Milestone and Derailers will be included in the resource folder to educate families about how to honor their loved one, while continuing to grieve and heal with the potential of being briefly derailed.

Summary and Comparison of Services

The summarizing table below shows a comparison of services offered by a variety of organizations or other programs. As the table shows below, there are no other programs that offer the wide variety of services that the Grief Hospitality Program provides.

Table 3: Services Comparison - Summarizing Table

Organization/Program	Services Offered
Grief Hospitality Program	• Private Room / Family Waiting Room • Immediate Family Presence in Patient Room • Food and Beverage • Hotel Accommodation Support • Parking Validation • Comfort Cart Supplies • Communication Services / Strategies • Post Hospitalization Follow-Up • Resources for Team Members / Medical Team • Resources for Families
Neuroscience ICU, Augusta University Health	• Butterfly Cart (comfort cart items)
McMaster Children's Hospital	• Legacy Creations (hand molding kits, digital stethoscopes, etc.)
Mayo Clinic	• Effective Communication Strategies • Post Hospitalization Follow-Up
EMS Personnel	• "Griev_ing Pneumonic"

Advertising and Marketing

A portion of advertising and marketing will be targeted toward the team members to ensure they know that the programs exist. There are plans and a budget to have a website designed explaining what the Grief Hospitality Program provides to families and how team members can contact the On-Call Nurse Leader or Program Director. The Program Director will also create brochures, business cards, and compose emails to distribute to all team members to learn more about the program. The website and emails will be used to advertise to donors to help fund the program as well as "spotlight" those who decide to become donors as a "thank you". Social media platforms will be utilized to advertise and "spotlight" our program and donors. Advertising and marketing will be used to promote fundraising events that the Executive Director and Program Director will be hosting throughout the community. The brochures and business cards mentioned above will be distributed at the fundraising events to potential donors. As you will read in the financial section, money maps will be created by the Executive Director and Program Director to be used as marketing materials. The money maps will clearly show where the donors' money will be spent. See Appendix II for an example of a simple brochure that will be distributed and could also be used as an email newsletter to send to team members or potential donors.

Financials

Funding Needs

As you will see below in the Budget Assumption section, the program will be funded solely through grants and donations. See below for more information regarding the program's funding needs.

Financial Literacy

"Financial literacy is the ability to understand and effectively use various financial skills, including personal financial management, budgeting, and investing. The lack of these skills is called financial illiteracy" (Fernando, 2020). Because this program will only be funding partial salaries of three people, financial literacy will be most important to the Executive Director and Program Director, as they will be the sole people responsible for keeping track of the budget. A financial literacy strategy that could be used to measure the performance of the Executive Director and Program Director would be to track the donation amounts for each year. Because the program only consists of three people, the Executive Director and Program Director can meet quarterly to assess their performance and brainstorm new ideas and ways to increase donor interests. Another reason to increase financial intelligence would be to benefit the donors. The Program Director can create money maps to give to donors or potential donors so they can see exactly how their money is being spent. Although this program will be housed in the Trauma Center, it is still operating within a large hospital system, which means leadership support from the top is crucial. "The stronger the support, the more likely it is that people throughout the organization will buy into the idea" (Berman, et al, pg. 253). The Executive Director must work with hospital leadership to ensure there is support from the top. Leadership can then promote the program as well as

potentially buy-in to the program. Most of the time, hospital leadership are also associated with organizations within the community. The Grief Hospitality Program can benefit from this collaboration as leadership can help promote the program to outside organizations.

Start-Up Costs

The start-up costs are going to be heavy up front, as we will need to pay the partial salaries of the three team members, purchase and stock the comfort carts, and develop a website and marketing plan. The Executive Director and Program Director plan to start with two comfort carts located in the trauma center at Indiana University Health Methodist Hospital in Indianapolis, Indiana. As mentioned above, in 2019, the trauma volume at Methodist Hospital was 3,352 patients. While the program intends to be able to provide to as many families as possible, the assumption is that in the first year, the program will help the families of approximately 100 tragically affected trauma patients. This seems like a very low number, but the hope is to increase this amount each year as more revenue is generated through additional grants and/or donations. The startup costs include the following:

- Salaries
- Comfort Carts
- Comfort Cart Supplies
- Parking Validations
- Meal Vouchers
- Advertising and Marketing
- Cell Phone Allowance
- Miscellaneous Costs

See below for a breakdown of the start-up costs for the program.

Table 4: Start-Up Costs

Start-Up Costs

Program Expenses	
Salaries	$62,911.75
Comfort Cart Supplies	$5,994.58
Parking Validations	$500.00
Meal Vouchers	$800.00
Miscellaneous	$1,000.00
Total Program Expenses	**$71,206.33**
Administrative Expenses	
Advertising & Marketing	$5,000.00
Cell Phone(s)	$1,800.00
Total Administrative Expenses	**$6,800.00**
Total Startup Costs	**$78,006.33**

Detailed Budget

The detailed budget, as you will see below, lists the revenues and expenses (program and administrative) for the program. Like mentioned above, the detailed budget is based on helping 100 families within the first year of start-up. The detailed budget for year two is based on adding an additional comfort cart (bringing the total carts to three) and restocking the comfort cart for an additional 75 families with the assumption that there will be some supplies turned over from year one as the program will just be getting off the ground. Assuming that the program receives a two-year, $250,000 grant (more information about this below in the Budget Assumption), there will be approximately $100,000 left after the first two years to help with additional expenses throughout the years. This can be used to purchase additional supplies for the comfort carts if the Program Director sees that there is a need to restock mid-year or in other ways such as hosting a fundraising event to bring in potential donors.

Table 5: Detailed Budget

Detailed Budget					
		Year 1		Year 2	
Revenue		**Amount**		**Amount**	
Grants		$250,000.00		$0.00	
Donations		$5,000.00		$25,000.00	
Total		**$255,000.00**		**$25,000.00**	
		Year 1		Year 2	
Total Revenue		**$255,000.00**		**$25,000.00**	
Program Expenses	**Cost**	**Quantity**	**Total Cost**	**Quantity**	**Total Cost**
Salaries					
Executive Director (0.25 FTE)	$27,167.75	1	$27,167.75	1	$27,167.75
Program Director (0.25 FTE)	$13,236.25	1	$13,236.25	1	$13,236.25
On-Call Nurse Leader (0.25 FTE)	$22,507.75	1	$22,507.75	1	$22,507.75
Comfort Cart Supplies					
Comfort Cart	$209.99	2	$419.98	1	$209.99
Snacks (Granola Bars, 60 pack)	$8.48	4	$33.92	3	$25.44
Snacks (100 Calorie Snacks, 18 pack)	$9.98	8	$79.84	6	$59.88
Blankets	$9.98	75	$748.50	60	$598.80
Kleenex (12 pack)	$14.98	10	$149.80	8	$119.84
Toiletry Kit (Deodorant, Toothbrush/Toothpaste, Comb, Face Wash)	$10.95	100	$1,095.00	75	$821.25
Molding Hand Kit	$29.95	100	$2,995.00	75	$2,246.25
Fuzzy Socks (7 pack)	$14.99	10	$149.90	8	$119.92
Activity Books (Cross Word, Word Search, etc., 12 pack)	$6.99	10	$69.90	8	$55.92
Playing Cards (12 pack)	$15.98	10	$159.80	8	$127.84
Eye Mask (30 pack)	$30.98	3	$92.94	2	$61.96
Parking Validations (Daily Rate)	$5.00	100	$500.00	75	$375.00
Meal Vouchers	$8.00	100	$800.00	75	$600.00
Miscellaneous	$1,000.00	1	$1,000.00	1	$1,000.00
Subtotal			**$71,206.33**		**$69,333.84**
Administrative Expenses	**Cost**	**Quantity**	**Total Cost**	**Quantity**	**Total Cost**
Advertising & Marketing	$5,000.00	1	$5,000.00	0.25	$1,250.00
Cell Phone Allowance ($50 per team member, per month)	$150.00	12	$1,800.00	12	$1,800.00
Subtotal			**$6,800.00**		**$3,050.00**
			Year 1		Year 2
Total Cost of Expenses			**$78,006.33**		**$72,383.84**

Budget Assumption

Below are the assumptions that outline the budget broke down by revenues and expenses:

Revenues

i. Grant(s): The Indiana University Health Foundation has administered grants to programs to "fund projects that address IU Health priorities" (Indiana Health University, 2018). Each grant has different agreements they abide by but the hopes for the Grief Hospitality Program would be a two-year, $250,000 grant that can be renewed at the end of the two years. The Executive and Program Director will also apply for additional grants outside of Indiana University Health in hopes to secure other revenues.

ii. Monetary Donations: The assumption is that the Executive Director and Program Director will work to secure donations from community members to help fund the program. Another potential source of revenue would be an employee buy-in option. Indiana University Health team members can easily work with Human Resources and the Payroll Department to have a certain amount or percentage automatically be deducted from their paycheck to go towards any type of program that the Indiana University Health Foundation houses.

iii. Supply Donations: The Executive and Program Director will accept donations of supplies from community members, organizations, etc. If there is a group or organization would like to support the Grief Hospitality Program, please have them consider donating the following items: blankets/quilts, fuzzy socks, travel-size toiletries, tissues, books/magazines, phone charges, etc.

Expenses (Program and Administrative)

i. Executive Director: The assumption is that the Executive Director will only be 0.25 FTE. Once this program is launched, the Executive Director will only work on a part-time basis to ensure the program is meeting its goals and staying on budget. The Executive Director will work to secure donations throughout the year by attending events at the hospital to promote the program and reaching out to potential donors. The salary that was assumed for the Executive Director came from Glassdoor, where the annual salary for a Healthcare Director was divided by four to get the 0.25 FTE (*Salary: Healthcare Director, 2020*. This salary will be recurring every year.

ii. Program Director: The assumption is that the Program Director will only be 0.25 FTE. Once this program is launched, the Program Director will only work on a part-time basis to ensure the comfort carts are fully stocked and to work closely with the On-Call Nurse Leadership when they have questions or concerns about the program or if they need help determining when to help families and in what capacity. The Program Director will work alongside the Executive Director to secure donations throughout the year. Social media and monitoring the website will be another responsibility of the Program Director. The salary that was assumed for the Program Director came from Glassdoor, where the annual salary for a Program Director was divided by four to get the 0.25 FTE (*Salary: Program Leader*, 2020). This salary will be recurring every year.

iii. On-Call Nurse Leadership: The assumption is that the On-Call Nurse Leadership will only be 0.25 FTE. Once this program is launched, the On-Call Nurse Leader will work with the clinical staff to determine when the comfort care should be accessed or if the program can

help the families in any other ways. The On-Call Nurse Leader will also work closely with the Program Director to ensure the families are being cared for in the best way possible. The salary that was assumed for the On-Call Nurse Leader came from Salary.com, where the annual salary for a Clinical Nurse Leader was divided by four to get the 0.25 FTE (*Clinical Nurse Leader Salary, 2020).* This salary will be recurring every year.

iv. Program Supplies (Comfort Carts and Inventory): The assumption for the program supplies comes from a variety of sources who have implemented comfort carts at their facilities. The comfort carts will be placed in the Trauma Center at Methodist Hospital and will contain the following items: snacks (granola bars and low calorie snacks), light-weight blankets, Kleenex, toiletry kit, fuzzy socks, activity books, playing cards, and eye masks for sleeping. The costs for these items were found online using Sam's Club and Amazon as they both sell these items in bulk. The assumption is that the costs of supplies will be greater at start-up to stock up supplies for the year. Although the Executive Director and Program Director plan to increase the number of families the program will provide support to in the coming years, they anticipate there will be some items leftover that can be used in following years.

v. Parking Validations: The assumption for parking validation is based on the daily rate of the visitor-parking garage at Methodist Hospital (*Indiana University Health – Garage # 1, 2018).* This is based off 100 validations being issued throughout the first year of the program. The Executive Director and Program Director anticipate that these costs will increase the following years as the program grows.

vi. Meal Vouchers: The assumption of meal vouchers was based on the average cost of a meal at the cafeteria in Methodist Hospital. Meal vouchers can come in any denomination. This based this off 100 vouchers being issued throughout the first year of the program. The Executive Director and Program Director anticipate that these costs will increase the following years as the program grows.

vii. Advertising and Marketing: The assumption for advertising and marketing for the program is based solely on the cost of creating a website for the program, which can range anywhere from $3,000-$5,000 (Brinker, 2020). The assumption for marketing will be mostly done through the website and social media platforms, which are free of charge. In future years, plans include using some of these funds to host small fundraising events to increase revenue. The assumption is that Donor Recognition (those who donate to the program) will also be done on the website and social media. These costs will be greater at start-up due to website development but will like decrease as the program grows.

viii. Cell Phone Allowance: The assumption is that each team member (Executive Director, Project Director, and On-Call Nursing Leadership) will receive a cell phone allowance of $50 each, every month. This will allow for them to use their personal cell phones when needing to contact each other, families they are supporting, or other members of the healthcare organization in reference to the Grief Hospitality Program. These costs will be recurring every year.

Training and Implementation

One of the many responsibilities of the Program Director will be to develop a training program for the team members to participate in. Team members will also receive brochures and emails to learn about the program, but the training program will go into more detail about the program and how to provide service to a family. Training will be mandatory for the team members who are working in the Trauma Center and it will need to be completed annually. The training program will be optional, but available to team members who do not work in the Trauma Center if they wish to learn more about the program. Training will be offered virtually as well as in person to accommodate all shift schedules and will last approximately one (1) hour. The one (1) hour training program will be used to show team members what supplies are in the comfort cart, other services the program offers, contact information for those in charge of the program, and resources for team members when they have a patient who dies. The training program will also be used to receive feedback from team members on how the program is working, what supplies are the most popular, what could be improved, etc.

Ethical Considerations

There are always ethical considerations to think about when implementing a healthcare program. In this case, there are a variety of things that could be considered ethical dilemmas. While one may think that a patient does not want to die alone, an incapacitated patient does not have the ability to decide whether or not they want their family present. If it is not in writing, it becomes hard to decide to let the immediate family in the patients room as this could violate their privacy if they had decided they did not want their family to see them in their current state; going against their autonomy ("Should Family Be Permitted in a Trauma Bay?," 2018, pg. 457). Another ethical consideration would be which patient's families are going to receive the services offered by the Grief Hospitality Program. The hope is to have enough supplies that eventually all families of actively dying trauma patients will be able to access the comfort cart, receive food vouchers/parking validation; but that is not realistic at the implementation of this program. The On-Call Nurse Leader and the medical team will need to assess the situation and make a decision if they feel they have a family that could benefit from the supplies of the comfort cart. The other resources of the program, such as the non-monetary resources, should always be provided to families, as that is just the quality of care that is expected to be provided. An additional ethical consideration would be to avoid the use of religious items in the comfort cart, as not all patients and families have the same religious views. It is also inappropriate to assume someone's religion based on his or her appearance. If a family wants to discuss religion, they can request the presence of a Chaplain (Goymour et al., 2018, pg. 203).

Pandemic Effects

The Coronavirus Pandemic, also known as COVID-19, has affected the healthcare industry in a huge way. While COVID-19 affected the healthcare industry in many ways, below are ways that the pandemic would have negatively influenced the Grief Hospitality Program, had it been implemented before the pandemic occurred.

Visitor Restrictions

One of the biggest issues the healthcare industry is facing during this difficult time would the visitor restrictions that organizations are putting into place. Each organization, location, etc., have different restrictions but almost every hospital, especially Indiana University Health hospitals, completely eliminated visitors for patients. During the most detrimental time of COVID-19, adult patients were not allowed any visitors, inpatient or outpatient. Of course, the pediatric world is a little different, but the majority of these traumatic injuries occur in adults. The saddest part of the visitor restrictions would mean that these patients are more than likely dying without their family by their side. With this being said, there would not be family members in the hospital who would be able to take advantage of the program.

Unused Supplies

With the visitor restrictions mentioned above, this would result in many of the supplies going unused. This should not have a large impact on the program supplies, as most of them are not food items, but this would be the reason the only food options for the comfort carts are limited to those that do not expire for a long period of time, such as granola bars.

Limited Funding

Many organizations have tightened their purse strings because of the Coronavirus Pandemic. While the healthcare industry has been very busy with treating COVID-19 patients, distributing vaccinations, and still caring for their most critical patients, health systems are not distributing discretionary money, as they tend to do when not in the midst of a pandemic. The Program Director will not only be asking for donations from the healthcare system, but also organizations outside of the health system and outside of the industry. Many organizations throughout the community are willing to support a program such as the Grief Hospitality Program; but funding during COVID-19 is very hard to obtain because no one really knows how long the pandemic will last and are trying to be very frugal in these trying times.

Conclusion

As previously stated, implementing a Grief Hospitality Program in Indiana University Health's Trauma Center can be very beneficial to family members of actively dying patients. This program would provide many services to these family members and could really change the overall healthcare experience, even though it does not directly affect the patient. Hospital systems, such as Indiana University Health, could greatly benefit from a program such as this to help improve the quality of care, employee satisfaction, and patient/family outcomes. It is true that not all families will benefit from this program, but research suggests that those who were offered similar services at other health systems, such as in the Neuroscience ICU at Augusta University Health, benefitted in many ways from being offered grief support through different resources. While the Grief Hospitality Program provides similar services offered by programs at other organizations, there is no findings of a program that offers this wide variety of services within a single program, which will make this program stand out substantially.

Limitations of Research

The research and implementation of this program has potential limitations. The Coronavirus Pandemic, or COVID-19, had an enormous impact on the limitations of research for the Grief Hospitality Program. Due to COVID-19, there is a lack of professional expertise surrounding this topic and support of the program. Many healthcare professionals are required to work from home because of the Coronavirus Pandemic, which meant there were no interviews of healthcare professionals conducted to get their input of the program. Due to time constraints and COVID-19, there is a lack of primary research, which include interviewing families, Directors of other programs across the health system, surveys, questionnaires, etc. The lack of funding in the start-up of this program resulted in limited primary research, as there was no funding to pay a researcher.

Future Research

"Future research is needed to explore the potential role for social work in providing hospital bereavement support…" (Moon et al., 2019). This research could result in the program utilizing Social Workers more frequently if they were able to provide additional support to grieving families before they leave the hospital. Quality improvement research can and should be done with the medical team and other team members to assess the quality of the program from their perspective. Quality improvement will also be done with families who utilized the program to evaluate their perception of the program and what aspects were beneficial to them and what did not seem to help them (Goymour et al., 2018). Another thing that could be researched in the future would be the usage of resources given to families when leaving the hospital after their loved one passes. It would be beneficial to identify what resources families are more likely to use and which ones they are not utilizing. Additional primary research will be done in the future. The first round of primary research could be conducted a year after implementation of the program. A piece of this research would include interviews of program directors to get a better understanding of how known the program is across the organization. Other primary research that will be conducted would include interviewing family members who utilized services offered by the program and sending surveys to families as well as the healthcare professionals who were involved in the care of the patient who passed.

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Appendix I

Figure 5: Comfort Cart Example I

(Hubert Company, LLC)

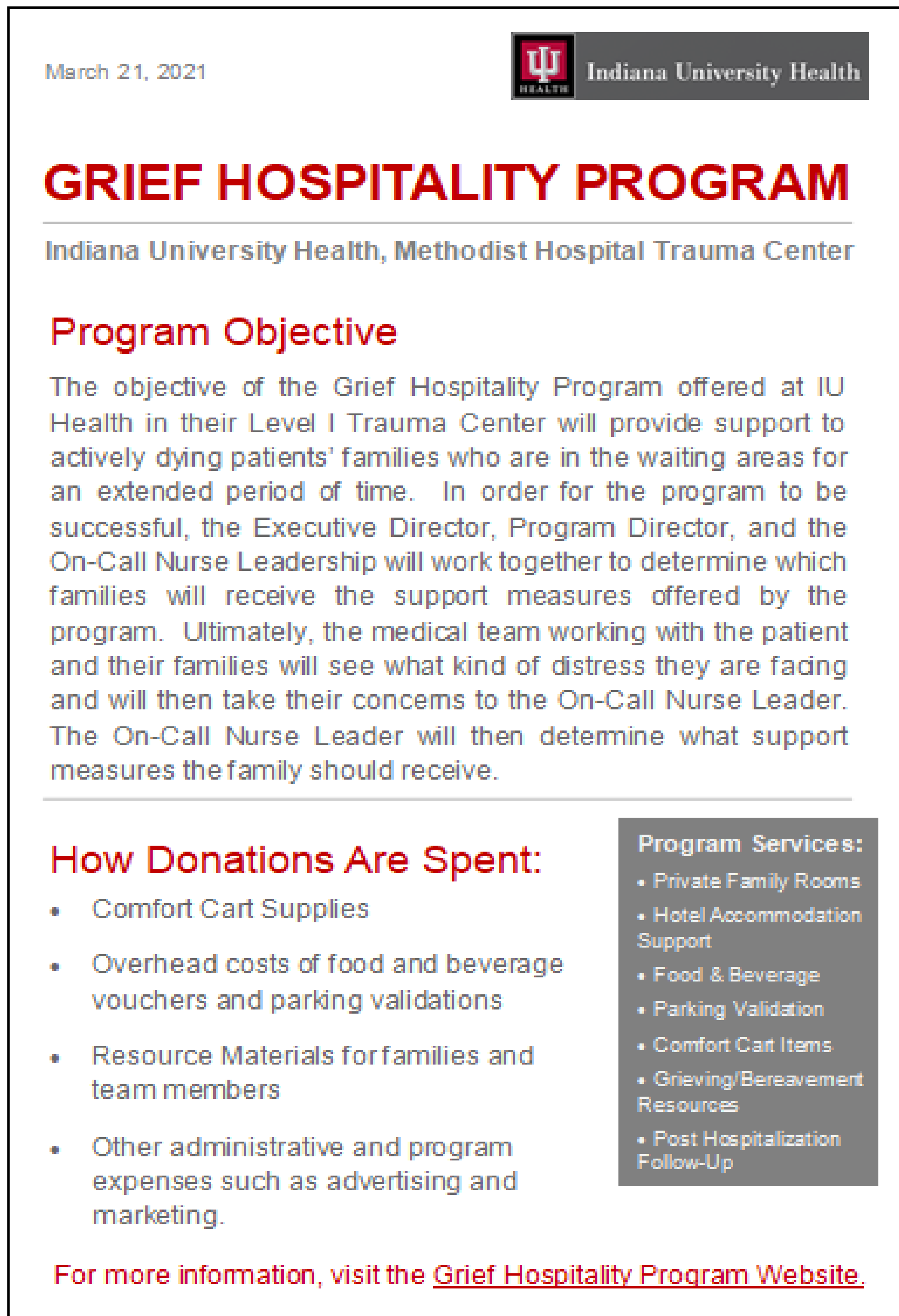
Figure 6: Comfort Cart Example II

(Olgin, 2017)

Appendix II

Brochure/Email Newsletter Example

Figure 7: Brochure/Email Newsletter Example



March 21, 2021

Indiana University Health

GRIEF HOSPITALITY PROGRAM

Indiana University Health, Methodist Hospital Trauma Center

Program Objective

The objective of the Grief Hospitality Program offered at IU Health in their Level I Trauma Center will provide support to actively dying patients' families who are in the waiting areas for an extended period of time. In order for the program to be successful, the Executive Director, Program Director, and the On-Call Nurse Leadership will work together to determine which families will receive the support measures offered by the program. Ultimately, the medical team working with the patient and their families will see what kind of distress they are facing and will then take their concerns to the On-Call Nurse Leader. The On-Call Nurse Leader will then determine what support measures the family should receive.

How Donations Are Spent:

- Comfort Cart Supplies
- Overhead costs of food and beverage vouchers and parking validations
- Resource Materials for families and team members
- Other administrative and program expenses such as advertising and marketing.

Program Services:

- Private Family Rooms
- Hotel Accommodation Support
- Food & Beverage
- Parking Validation
- Comfort Cart Items
- Grieving/Bereavement Resources
- Post Hospitalization Follow-Up

For more information, visit the Grief Hospitality Program Website.